

STATE OF NEW JERSEY

**STATE
HEALTH BENEFITS
PROGRAM**

NJ PLUS

**MEMBER
HANDBOOK**

FOR EMPLOYEES AND RETIREES

**Department of the Treasury
Division of Pensions and Benefits**

**Administered by
Horizon Blue Cross Blue Shield of New Jersey**

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INTRODUCTION

This Handbook, your plan document, is designed for use by participants enrolled in the State Health Benefits Program (SHBP) NJ PLUS Plan. Keep this handbook where you can access it when you have questions about your health **coverage**.

Terms in this handbook that are printed in **bold** text are explained in the Glossary (beginning on page 67).

State law and the New Jersey Administrative Code govern the SHBP. The State Health Benefits Commission is the executive organization responsible for overseeing the State Health Benefits Program. The Commission includes the State Treasurer, the Commissioner of the Department of Banking and Insurance, and the Commissioner of the Department of Personnel or their designated representatives. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP.

NJ PLUS is a **point of service** plan that is a blend of a traditional indemnity plan and an HMO. It provides managed care to its members through its own network of providers. It also offers **out-of-network** benefits which provide reimbursement to providers and members for expenses for services rendered for the treatment of **illness** and **injury**. NJ PLUS is self-funded. Payment of claims and services comes from an SHBP fund supplied by the State or participating **local employers** and **members**. NJ PLUS is currently administered for the SHBP by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) which means that Horizon BCBSNJ is the claims payer for all eligible members.

NJ PLUS offers:

- A network of providers, which includes **primary care physicians** (PCP) internists, general practitioners, pediatricians, specialists, and hospitals.
- A full range of services when you use network providers to include well-care and preventive services such as annual physicals, well-baby/well-child care, immunizations, mammograms, annual gynecological examinations, and prostate examinations.
- In-network services, which are generally covered in full after a \$5.00 **co-payment**.
- No filing of claim forms when you use in-network services.
- In-network hospital admissions covered in full.
- An out-of-network option whereby you may use providers who are not in the network and receive a 70 percent reimbursement of the **reasonable and customary** allowance for most care after a deductible is met.



STATE HEALTH BENEFITS PROGRAM INFORMATION

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for **coverage** is determined by the State Health Benefits Program (SHBP). Enrollments, terminations, changes to contracts, etc. must be presented through your employer to the SHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

To be eligible for **State employee** coverage, you must work full-time or be an appointed or an elected officer of the State of New Jersey. For State employees, full-time normally requires 35 hours per week.

To be eligible for **local employer** coverage, you must be a full-time employee or an appointed or elected officer receiving a salary. Each employer defines the minimum hours required for full-time by a resolution filed with the SHBP, but it can be no less than an average of 20 hours per week. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year.

Eligible Dependents

Your eligible dependents are your spouse and/or your unmarried children under age 23 who live with you in a regular parent-child relationship. This includes children who are away at school as well as divorced children living at home and dependent upon you for support. If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases. Coverage for an enrolled child will end when the child marries, moves out of the household, or turns age 23. Coverage for children age 23 ends on December 31 of the year in which they turn age 23 (see the **COBRA** section on page 10 for continuation of coverage provisions).

If a child is not capable of self-support when (s)he reaches age 23 due to mental **illness**, mental retardation, or a physical disability, coverage under the SHBP may be continued. To request continued coverage, call or write the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625-0299 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Enrollment

You are not covered until you enroll in the SHBP. You must fill out a *NJ State Health Benefits*

Program Application and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so (see exceptions below). Open Enrollment periods generally occur once a year. Information concerning the duration of the Open Enrollment period and effective dates of coverage are announced by the Division of Pensions and Benefits.

Change of Coverage

To change your coverage you should contact your benefits administrator or human resource representative and complete a *NJ State Health Benefits Program Application*. You are eligible to change your coverage under the following circumstances.

- You marry and want to enroll your spouse and newly eligible dependent children. You must file a new *NJ State Health Benefits Program Application* within 60 days of the marriage.
- You need to enroll a new child. You must file a new *NJ State Health Benefits Program Application* within 60 days after birth or adoption and submit legal documentation.
- You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives with you, or turns 23).
- You move out of a plan's service area. You can change immediately; however, if you do not change within 30 days of the move, you must wait until the next Annual Open Enrollment period.
- You are going on a leave of absence and cannot afford to pay for coverage. You can reduce your coverage, for example, from family to parent and child when you go on leave and increase it back to family upon your return to work.
- Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage. You have 60 days from the date of the event to make adjustments to your coverage that are necessary to compensate for the loss of this coverage. A copy of your spouse's and or dependent's Certificate of Continued Coverage must be submitted with the *NJ State Health Benefits Program Application*.
- Your child, under the age of 23, has divorced and moves back into your household, and is dependent upon you for support and maintenance. You must file a *NJ State Health Benefits Program Application* within 60 days after the child has returned home, with a copy of the child's divorce decree, if you wish to enroll this child under your coverage.

Effective Dates of Coverage

There is a waiting period of two months following your date of hire before your SHBP health benefits coverage begins, provided you submit a completed *NJ State Health Benefits Program Application*. Your enrolled eligible **dependent's coverage** is effective the same date as yours provided you have paid any required contribution.

Coverage for **State biweekly employees** begins on the first day of your fifth payroll period. The

exact date of your coverage will be determined by the State's centralized payroll date schedule. Contact your benefits administrator or human resource representative if you need to know the exact date of coverage.

If you are a local government or local education employee or a **State monthly employee**, your coverage begins on the first day following two months of employment. For example, if you start work on September 15, your coverage will be effective November 15. The following *exceptions* apply to this effective date of coverage.

- If you have at least two months of service on the date your employer joins the SHBP, your coverage starts on the date your employer enters the program.
- If you have an annual contract, are paid on a 10-month basis, and begin work at the beginning of the contract year, your coverage will begin on September 1.
- If you were enrolled in the SHBP with your previous employer and your coverage is still in effect on the day you begin work with your current employer (**COBRA** coverage excluded), your coverage begins immediately so you have no break in coverage. (See Transfer of Employment, below.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, birth, adoption, etc.) providing the application is filed within 60 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Health Benefits Bureau. Dependent children are automatically terminated as of the end of the year they attain age 23 and do not require the completion of an application to decrease coverage.

Transfer of Employment

If you transfer from one SHBP-eligible employer to another, including transfer within State employment, coverage may be continued without any **waiting period** provided that you:

- are still covered by the SHBP (**COBRA** coverage excluded) when you begin in your new position; or
- transfer from one participating employer to another; and
- file a new *NJ State Health Benefits Program Application* listing the former employer in the appropriate section of the application.

Leave of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for **illness**.
- Approved leave of absence other than illness.
- **Family Leave Act** (federal and state).
- Furlough.
- Workers' Compensation.
- Suspension (**COBRA** continuation only).

When you take an approved leave of absence, you may reduce your coverage (for financial reasons) and increase it again when you return from leave. When you return to work, your benefits and those of your eligible family members are reinstated upon completion of a *NJ State*

Health Benefits Program Application. Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence. When the leave of absence is due to suspension, you are not eligible for benefits, with the possible exception of **COBRA**.

Family and Medical Leave Act

State and **local employees** participating in the SHBP are entitled to have their coverage continued at the expense of their employer while they are on family leave. To qualify for the federal Family and Medical Leave Act of 1993 (FMLA), you must have a personal illness, a newborn child, or need to care for an ill family member, and be employed for 12 months. The FMLA defines the family member as a spouse, parent, or child. The FMLA provides up to 12 weeks in a 12-month period.

To qualify for the New Jersey Family Leave Act (NJFLA), you must have a need to care for an ill family member or a newborn child. There is no provision for an employee's own personal illness. The NJFLA provides up to 12 weeks in a 24-month period.

If an employee takes a leave for the care of a family member, both the FMLA and the NJFLA will run concurrently. If an employee takes a leave for maternity, they are on the FMLA. After their doctor releases them from their maternity leave, they can take the NJFLA for the care of the newborn child. This then provides the parent with up to 24 weeks of employer paid benefits.

Furlough

If you take an approved furlough, your SHBP coverage will continue at the employer's expense. You must remit to your employer, in advance, that portion of the premiums you normally pay, if any.

For State employees, voluntary furlough extensions beyond the normal 30 days allowed will be treated as an exceptional case. You will have to pay for the full cost of coverage for your extended furlough days in 10-day increments or drop your coverage for the entire **benefit period(s)** in which you take a furlough day.

End of Coverage

Coverage for you and your dependents will end if:

- you voluntarily terminate coverage;
- your employment terminates;
- your hours are reduced so you no longer qualify for coverage;
- you take a leave of absence and do not make required premium payments;
- you enter the Armed Forces and are eligible for government-sponsored health services;
- your employer ceases to participate in the SHBP; or
- the SHBP is discontinued.

Coverage for your dependents will end if:

- your coverage ceases for any of the reasons listed above;

- you die;
- your dependent is no longer eligible for coverage (divorce of a spouse; children marry, move out of the household, or turn age 23 unless the dependent child qualifies for continuance of coverage due to disability — see page 1);
- your payment for coverage is not made when due; or
- your enrolled dependent enters the Armed Forces.

Return from Leave of Absence

If your coverage has terminated while on an approved leave of absence, when you return from the leave, your benefits and those of your eligible family members are reinstated after you complete a *NJ State Health Benefits Program Application*. **You must complete this application within 60 days after you return to work.** Coverage becomes effective on the date you return to work if you are a State monthly or local employee or on the first day of the pay period in which you return to work if you are a State biweekly employee. You may enroll in any plan at any level of coverage for which you are eligible when you return from an approved leave of absence. This reinstatement provision applies to all approved leaves.

If you retained your coverage at a reduced level while on an approved leave of absence, you may return to your former level of coverage or any other eligible level of coverage upon your return to work.

If you retained your coverage at a reduced level while on a leave of absence and were not actively at work during an Open Enrollment period, you may make certain types of changes to your coverage when you return to work. These changes will be effective immediately upon your return to work.

If you are absent for a full pay period (State biweekly employee) and your coverage was terminated, or you purchased **COBRA** coverage while on leave, you must file a new *NJ State Health Benefits Program Application* **within 60 days** of the first day of your return to work. In addition, filing your application as soon as possible upon your return to work will help to ensure a timely re-enrollment.

Workers' Compensation

If you have a Workers' Compensation award pending or have received an award of periodic benefits under Workers' Compensation or the Second Injury Fund, you and your dependents are entitled to have continued coverage at the same contribution level as when you were an active employee. You must remit to your employer, in advance, that portion or the premiums that you would normally pay, if any.

Medicare Parts A and B

It is not necessary for a **Medicare**-eligible employee or spouse to be covered by Medicare while they remain actively at work. It is required that they enroll in both Parts A and B prior to retirement so that coverage will be effective at the time of retirement.

RETIREE COVERAGE

The SHBP is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in the SHBP's **Retired Group** coverage. Early filing is recommended to prevent any lapse of coverage or delay of eligibility.

Medicare Coverage

IMPORTANT: A Retired Group member and/or dependent spouse who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP Retired Group coverage.

You will be required to submit documentation of enrollment in Medicare Parts A and B when you become eligible for that coverage. Acceptable documentation includes a photocopy of your Medicare card showing both your Part A and B enrollment or a letter from Medicare indicating the effective dates of both your Parts A and B coverage. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, 50 West State Street, PO Box 299, Trenton, New Jersey 08625-0299. If you do not submit evidence of Medicare coverage under both Parts A and B, you and/or your dependents will be terminated from the SHBP. Upon submission of proof of **full Medicare coverage**, your coverage will be reinstated by the SHBP.

IMPORTANT: If a provider does not participate with Medicare, no benefits are payable under the SHBP for the provider's services.

A **member** may be eligible for Medicare for the following reasons:

— ***Medicare Eligibility by Reason of Age***

This applies to a **member** who is the employee or covered spouse and is at least 65 years of age.

A member is considered to be eligible for Medicare by reason of age from the first day of the month during which (s)he reaches age 65. However, if (s)he is born on the first day of a month, (s)he is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The health plan is the secondary plan.

— ***Medicare Eligibility by Reason of Disability***

This applies to a member who is under age 65.

A member is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months.

The health plan is the secondary plan.

— ***Medicare Eligibility by Reasons of End Stage Renal Disease***

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to

ESRD, Medicare is the secondary payer when:

- The individual has group health coverage of their own or through a family member (including a spouse).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The above rules, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

As of 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "**coordination of benefits**" period; and (3) a period where Medicare is primary.

Three-month waiting period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the group health plan is primary.

Coordination of benefits period

During the "coordination of benefits" period, Medicare is secondary to the group health plan coverage. Claims are processed first under the health plan.

Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD after 1996, the coordination of benefits period is 30 months.

When Medicare is primary

After the coordination of benefits period ends, Medicare is considered the primary payer and the group health plan is secondary.

— Dual Medicare Eligibility

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then the group health plan continues to be primary for 30 months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then the health plan continues to be the secondary payer. There is no 30-month coordination period.

How to File a Claim If You Are Covered by Medicare

When filing your claim, follow the procedure that applies to you.

When Using New Jersey Physicians or Providers:

- You should provide the physician or **provider** with your identification number.

This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."

- The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an *Explanation of Benefits* form from Medicare.
- If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to (name of your SHBP plan) for their consideration in processing supplementary coverage benefits."
- If the above statement does not appear on the *Explanation of Benefits*, you should indicate your Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form.

When Using Out-Of-State Physicians or Providers:

- The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.
- When you receive the *Explanation of Benefits*, indicate your identification number and the name and address of the physician or provider in the remarks section and send the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage except for Medicare requirements as stated above.

Change of Coverage

To change your coverage you should contact the Office of Client Services at the Division of Pensions and Benefits and request a *SHBP Retired Status Application*. You are eligible to change and should change your coverage under the following circumstances.

- You marry and want to enroll your spouse.
- You need to enroll a new child.
- You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives at home, or turns age 23).
- You wish to change your medical plan. A **Retired Group member** can switch medical plans once in any 12-month period or when rates change.
- Your spouse's employment status changes resulting in a significant change in health coverage.

IMPORTANT: Retirees should immediately notify the Health Benefits Bureau of changes in family status. (1) Deleting coverage for dependents may affect premium rates and,

although claims for ineligible dependents cannot legally be paid, *premiums cannot be reduced until appropriate notification is provided to the Health Benefits Bureau.* (2) Failure to submit a *SHBP Retired Status Application* to remove from your coverage a deceased or ineligible spouse for whom you receive a Medicare Part B reimbursement will result in the need for you to reimburse all incorrectly paid amounts.

SPECIAL RETIRED GROUP RULES

Limitations on Enrolling Dependents and Changing Coverage

Eligible dependents can be added to Retired Group coverage upon initial enrollment of the retiree and within 60 days of a change of family status (marriage, birth of child, etc.) that made the dependent eligible. The family member will be enrolled retroactive to the date of eligibility.

If the application to add a spouse or dependent is not received within 60 days of the status change, there will be a minimum 2 month **waiting period** from the date the enrollment application is received until the member is covered — beginning the first of the month following the expiration of the waiting period. You may remove family members from coverage at any time. Decreases in coverage will be processed on a timely basis. **It is your responsibility to notify the SHBP of any change in family status.** If family members are not properly enrolled, claims will not be paid.

Effective Dates

The effective date of any change in which a dependent is added to coverage because of **marriage, birth, or adoption** is the first of the month in which the event occurred if the *Retired Status Application* is filed within 60 days of the event (marriage, birth, adoption, etc.) with the SHBP. If the *Retired Status Application* is not received within 60 days of the event by the SHBP, the effective date will be the first of the month following a full two-month waiting period from the date of receipt of the application.

You are responsible for notifying the Health Benefits Bureau of a coverage change due to **death or divorce**. The effective date is the first day of the month following the date of death or divorce. Any claims incurred or services provided after this date are ineligible for payment.

The effective date of **any other change or termination of coverage** is based on the billing cycle in which the change or termination is received. In most cases, if an application for a change is received before, for example, January 15, the effective date will be February 1. If the application is received after January 15, the effective date will be March 1. The effective date of any transaction may be delayed if the member fails to submit the appropriate application and supporting information on a timely basis.

End of Coverage

Your coverage under the Retired Group terminates if:

- you formally request termination in writing, or by completing a *SHBP Retired Status Application*;
- your retirement is canceled;
- your pension allowance is suspended;

- you do not pay your required premiums;
- your plan discontinues services in your area and you do not submit an application to the SHBP to change to another plan;
- you or your spouse do not provide proof of enrollment in Medicare Parts A and B when eligible for Medicare coverage;
- your former employer withdraws from the SHBP (this may not apply to certain retirees of education, police, and fire employers);
- your Medicare coverage ends;
- you die; or
- the SHBP is discontinued.

Once coverage is terminated you are not normally permitted to be reinstated.

Survivor Coverage

If you, the retired member, predecease your covered spouse and/or other covered eligible dependents, your surviving dependents may be eligible for continued coverage in the SHBP. Surviving dependents are generally notified of their rights to continued coverage at the time the Division of Pensions and Benefits is notified of the death of the retiree; however, they may contact the Division of Pensions and Benefits' Office of Client Services for enrollment forms or for more information. It is imperative that survivors notify the Division of Pensions and Benefits as soon as possible after your death because their dependent coverage ends on the first of the month after the date of your death.

COBRA COVERAGE

Continuing Coverage When it Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (**COBRA**) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see Duration of Coverage, on page 11), and the member must pay the full cost of the coverage plus an administrative fee. The member/dependent can increase his or her level of coverage, i.e., add dependents or elect coverage (s)he did not have as a member/dependent.

Leave taken under the federal and/or State Family Leave Act is no longer subtracted from your COBRA eligibility period.

COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP medical coverage and, if offered by your employer, State prescription drug coverage during the SHBP Open Enrollment period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the SHBP Open Enrollment period as an active employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission makes changes to the

health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member.
- Reduction in work hours.
- Leave of absence.
- Divorce or legal separation (makes spouse ineligible for further coverage).
- Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, or marriage.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence**.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if (s)he becomes eligible because of your **death or divorce**, or (s)he becomes ineligible for continued group coverage because of **marriage, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage**.

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- notify you and your dependents of the COBRA provisions when you and your dependents are first enrolled;
- notify you, your spouse, and your children of the right to purchase continued coverage when they become aware of a COBRA event that causes a loss of coverage;
- send the *COBRA Notification Letter* and a *COBRA Application* within 14 calendar days of receiving notice that a qualifying event has occurred; and
- maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

- notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, or death has occurred or that your child has married, moved out of your household, or reached age 23 — notification must be given within 60 days of the date the event occurred;
- file a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- pay the required monthly premiums in a timely manner; and
- pay premiums, when billed, retroactive to the date of group coverage termination.

Termination of COBRA Coverage

Your COBRA coverage through the SHBP will end when any of the following situations occur:

- your eligibility period expires;
- you fail to pay your premiums in a timely manner;
- **after the COBRA event**, you become covered under another group insurance program (unless a pre-existing clause applies);
- you voluntarily cancel your coverage;
- your employer drops out of the SHBP;
- you become eligible for Medicare **after you elect COBRA coverage**. (This affects health insurance only, not dental, prescription, or vision coverage.)

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective October 21, 1998, the State Health Benefits Commission adopted as policy, the federal mandate "Women's Health and Cancer Rights Act of 1998." The mandate requires that plans, which cover mastectomies, must cover breast reconstruction; surgery to produce a symmetrical appearance; prostheses; and treatment of any physical complications.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal government plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Act Requirements

For the plan year that began January 1, 2001, all SHBP health plans will meet or exceed the federal requirements with the exception of mental health parity for the Traditional Plan and NJ PLUS. Parity requires that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Mental Health Parity

The State Health Benefits Commission has filed an exemption from the mental health parity requirement with the federal Health Care Financing Administration for **calendar years** 2000 and 2001. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS will not change, with the exception for **biologically-based mental illness** (see page 37). Maximum annual and lifetime dollar limits for mental health benefits are outlined on page 26.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* (COC) form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resource office, should you terminate your coverage.

PURCHASE OF INDIVIDUAL INSURANCE COVERAGE

Employees, retirees, and their dependents may purchase individual, direct payment coverage from their State Health Benefits Program (SHBP) health plan carrier if their loss of group health coverage is due to any reason other than voluntary termination. Note: failure to pay required premiums is considered voluntary termination.

Before considering a converted policy, New Jersey residents should first investigate coverage available under the provisions of the New Jersey Individual Health Coverage Program. Information about available policies can be obtained from the New Jersey Individual Health Coverage Board at the Department of Banking and Insurance. Carrier and rate information can be obtained by calling 1-800-838-0935 or at www.njdobi.org

If you are Medicare eligible you may qualify for a Medigap policy through the New Jersey Department of Health and Senior Services — State Health Insurance Program (SHIP). For more information, contact SHIP at 1-800-792-8820.

You will have 31 days from the end of your SHBP coverage to exercise your right to conversion.

EXTENSION OF BENEFITS

If you are disabled with a condition or illness at the time of your termination from the SHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this condition or illness. If you feel that you may qualify for an extension of benefits please contact your claims administrator for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension, under any SHBP plan, will be for the time a member remains disabled from any such condition or illness, but not beyond the end of the **calendar year** after the one in which the person ceases to be a **covered person**. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

CLAIM APPEAL PROCEDURES

You or your authorized representative may **appeal** and request that your health plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. The administrative appeal is described below. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures. This appeal process is described on page 43 under the Utilization Review Procedure.

Your initial appeal request may be taken over the phone. Any subsequent appeals must be filed in writing to the following inquiry address:

**NJ PLUS
Attention: Appeals Department
PO Box 820
Newark, NJ 07101**

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- employee's identification number;
- date(s) of service(s);
- provider's name and identification number;
- the specific remedy being sought; and
- the reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

If dissatisfied with a final health plan decision on an administrative appeal, only the member or the member's legal representative may appeal, in writing, to the State Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

**Appeals Coordinator
State Health Benefits Commission
PO Box 299
Trenton, NJ 08625-0299**

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days in writing to the Commission, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Failure to respond to the audit will result in the termination from coverage of eligible dependents. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated.

TERMINATION FOR CAUSE

If any of the following conditions exist, you may receive written notice that you will no longer be covered under NJ PLUS.

- If, after reasonable efforts, NJ PLUS and/or participating providers are unable to establish and maintain a satisfactory, provider/patient relationship with you or you repeatedly act in a manner which is verbally or physically abusive.
- If you permit any person who is not authorized to use the identification card(s) issued to you.
- If you willfully furnish incorrect or incomplete information in a statement made for the purpose of effecting coverage under NJ PLUS.
- If you abuse the system, including, but not limited to theft, damage to a participating providers' property, or forgery of prescriptions.

Any action by NJ PLUS under these provisions is subject to review in accordance with the established appeals procedures. If an appeal is denied and the decision upheld, this action is subject to appeal to the State Health Benefits Commission. No benefits, other than for emergencies, will be provided to the member and to any family members under the coverage as of 31 days after such written notice is given by NJ PLUS.

If the State Health Benefits Commission sustains the termination by NJ PLUS, no further benefits are available from the day a completed application for a change of coverage to enroll in another health plan offered through the SHBP is received and processed by the Division of Pensions and Benefits, Health Benefits Bureau.

If the State Health Benefits Commission overrules the decision to terminate, benefits will be restored.

NJ PLUS

GENERAL CONDITIONS OF THE PLAN

Benefits listed in this section may be subject to limitations and exclusions as described in subsequent sections. All pertinent parts of this handbook should be consulted regarding a specific benefit.

If a specific service or supply is neither described nor listed in this handbook, that does not in and of itself make the service or supply eligible under this plan.

Your **Primary Care Physician** (PCP) will ensure that your treatment is within the general conditions of the plan. However, if you go **out-of-network** you should know what will or will not be covered. The plan will pay only for eligible services or supplies that meet the following conditions:

- are medically needed at the appropriate level of care for the medical condition. When there is a question as to medical need, the decision on whether the treatment is eligible for coverage will be made by NJ PLUS.
- are listed in the Services and Supplies section.
- are ordered by a doctor (as defined by the plan) for treatment of illness or injury.
- were provided while you or your eligible family members were covered by the plan. (For example, if your coverage ended on August 31 and you were treated by a doctor for a broken leg on August 30, the doctor's bill is eligible even if you do not send it to NJ PLUS until some time after August 30. If, however, you were treated on September 1, the bill would not be eligible because you were not a member of the plan at the time the treatment was rendered.)
- are not specifically excluded (listed in the "Charges Not Covered by the Plan" section on page 45).

When you go out-of-network, all services, supplies, tests, etc. prescribed by the out-of-network provider, including hospitalization, are reimbursed at 70 percent of the **reasonable and customary** allowance.

Reasonable and Customary Allowances (For Out-of-Network Services)

The plan covers only reasonable and customary allowances (R&C), which are determined by the Prevailing Healthcare Charges System (PHCS) fee schedule based on actual charges by physicians in a specific geographic area for a specific service. If your physician charges more than the R&C allowance, you will be responsible for the full amount above the R&C allowance, in addition to any deductible and coinsurance you may be required to pay.

Experimental or Investigational Treatments

With the exception of approved cancer clinical trials, the plan does not cover treatment that is considered experimental or investigational. Charges in connection with such a service or supply are also not covered. For the purpose of this exclusion, a service or supply will be consid-

ered experimental or investigational if it is determined by the claims administrator that one or more of the following is true:

- The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to Phase I, II, and III clinical trials.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for a particular diagnosis or set of indications before it is used outside clinical trials or other research settings. The claims administrator will determine this based on:
 - published reports in authoritative medical literature; and
 - regulations, reports, publications, and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.
- In the case of a drug, device, or other supply that is subject to FDA approval:
 - it does not have FDA approval for sale and use in the USA (that is, for introduction into and distribution in interstate commerce); or
 - it has FDA approval only under the Treatment Investigational New Drug regulation or a similar regulation; or
 - it has FDA approval, but is being used for an indication or at a dosage that is not an acceptable off-label use. NJ PLUS will determine if a use is an accepted **off-label** use based on published reports in peer-reviewed, authoritative medical literature and entries in the following drug compendia — the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopeia Dispensing Information; or
 - it is an FDA-regulated product, service, supply, or drug under any FDA program other than FDA approval for introduction and distribution into interstate commerce.
- The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.
- The provider's institutional review board requires that the patient, parent, or guardian give an informed consent stating that the service or supply is experimental or investigational, part of a research project or study, or federal law requires such a consent.
- Research protocols indicate that the service or supply is experimental or investigational. This item applies for protocols used by the patient's provider as well as for protocols used by other providers studying substantially the same service or supply.
- The service or supply is not recognized by the prevailing opinion within the

appropriate medical specialty as an efficacious treatment for the particular diagnosis or set of indications.

Predetermination of Benefits (Out-of-Network)

A predetermination of benefits is required for all organ transplants. It is not required for any other service. A predetermination may, however, be obtained in writing in advance of services being rendered. The request will need to include a diagnosis, a description of the services to be rendered, and the anticipated charges. Telephone contact with NJ PLUS or the Division of Pensions and Benefits about coverage does not constitute a predetermination of benefits. If the actual services rendered differ from those described in the written request, the predetermination of benefits will have no effect.

Participating Out-of-Network Providers

If you live in New Jersey, Pennsylvania, or New York, you may be able to take advantage of a Horizon BCBSNJ special out-of-network program. In this program, out-of-network, **participating providers** contract with Horizon BCBSNJ for a discounted fee schedule. When you use a participating provider, Horizon BCBSNJ will pay the provider directly, and you will pay the provider 30 percent coinsurance based on the discounted fee and any applicable deductible amounts, thereby reducing your out-of-pocket cost. In addition, participating providers submit all claims directly to Horizon BCBSNJ eliminating the necessity of claim forms. To find out if your provider participates, call 1-800-414-SHBP (7427).

Other Blue Cross Blue Shield plans throughout the country have similar arrangements with providers in their areas of coverage. NJ PLUS members and their covered dependents are eligible to take advantage of the savings offered by using these participating providers. Contact the local Blue Cross Blue Shield plan in the area where you reside to identify participating providers.

Claims Appeal Procedures

You or your authorized representative may appeal and request NJ PLUS to reconsider any claim or any portion(s) of a claim for which you believe benefits have erroneously been denied based on the limitations and/or exclusions of NJ PLUS. This appeal may be of an administrative or of a medical nature.

You then have the right to appeal the NJ PLUS final decision to the State Health Benefits Commission, but it is your responsibility to demonstrate that the particular treatment falls within the terms and conditions of the plan. For more information on the appeals process, please refer to the "Appeals" sections on pages 14 and 43.

PRESCRIPTION DRUG BENEFITS

The State Health Benefits Commission requires that all employees and retirees and their dependents who are enrolled in the State Health Benefits Program have access to prescription drug coverage. If you are retired or if you are employed by a county, municipality, board of education, or other local public employer that does not offer a separate prescription drug plan to its employees, all health plans offered through the SHBP, including NJ PLUS, must include a prescription drug benefit. If you have prescription drug coverage through your employer or through

the SHBP Employee Prescription Drug Plan, the SHBP plans including NJ PLUS will not provide prescription drug coverage.

State active employees have a separate prescription drug plan called the Employee Prescription Drug Plan and do not have prescription drug coverage through NJ PLUS.

Active Employees (Whose employer does not provide prescription drug coverage)

If you are an active employee and your employer does not offer a prescription drug plan, NJ PLUS provides a discounted prescription drug reimbursement program. When you present your discount card to the pharmacist you are charged a reduced fee for your medication and your claim is electronically submitted to the carrier for payment. NJ PLUS will reimburse 90 percent of the cost of the prescriptions in-network and 70 percent of the cost of prescriptions, less deductibles, at the out-of-network level.

Retirees

As of January 1, 2000, a separate prescription drug card program with a co-payment design was introduced for retirees enrolled in NJ PLUS. The Retiree Prescription Drug Plan includes a mail order service for maintenance medications. All retiree prescriptions filled after January 1, 2000 will be administered through the Retiree Prescription Drug Plan and will not be reimbursed through NJ PLUS. Prescription drug co-payments and coinsurance amounts from the SHBP Retiree Prescription Drug Plan or other prescription benefit plans are not reimbursable through NJ PLUS. The following co-payment amounts are applied to prescriptions purchased through the Retiree Prescription Drug Plan.

Retail Pharmacy — up to a 90-day supply co-payment amounts

Supply	Generic	Preferred Brand	All Other Brands
01-30 days	\$5 co-payment	\$10 co-payment	\$20 co-payment
31-60 days	\$10 co-payment	\$20 co-payment	\$40 co-payment
61-90 days	\$15 co-payment	\$30 co-payment	\$60 co-payment

Mail Order — up to a 90-day supply co-payment amounts

Supply	Generic	Preferred Brand	All Other Brands
01-90 days	\$5 co-payment	\$15 co-payment	\$25 co-payment

There is a \$300 annual maximum in prescription drug co-payments per person. Once a person has paid \$300 in co-payments in a calendar year, that person is no longer required to pay any prescription drug co-payments for the remainder of that calendar year. Prescription drug co-payments are not eligible for reimbursement and do not apply to NJ PLUS out-of-network deductible or coinsurance amounts. Please note that over 99 percent of the pharmacies in New Jersey and 95 percent nationally participate with PAID Prescriptions. In the event a pharmacy does not participate with PAID Prescriptions, you should pay for the prescription and file a claim with: PAID Prescriptions, P.O. Box 723, Parsippany, NJ 07054-0723.

COORDINATION OF BENEFITS

Almost all group insurance programs provide for the coordination of benefits (COB), including NJ PLUS. A program without such a provision is automatically the primary program whenever its benefits are duplicated. **Please note: COB rules may change if Medicare is involved. Please refer to the "Medicare" section on page 6 for more information.**

For programs that do have this COB provision, the following rules determine which one is the primary program:

- If you, the active employee, are the patient, NJ PLUS is the primary program. If your spouse is the patient, and covered under a program of his or her own, that program is the primary program.
- If a dependent child is the patient and is covered under both parents' programs, the following birthday rule will apply:

Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday is July 16 and the mother's birthday is May 17, the mother's plan would be the primary for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary.

This birthday rule regulation affects all carriers and all contracts which contain COB provisions. It applies only if both contracts being coordinated have the birthday rule provision. If only one contract has the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.

If a dependent child is covered under an active SHBP contract and a retiree SHBP contract, the active SHBP contract would be primary for the dependent child and the birthday rule does not apply.

If two or more programs cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order.

- The program of the parent with custody is primary; followed by
 - the program of the spouse of the parent with custody of the child; then
 - the program of the parent not having custody of the child.
 - If it has been established by a court decree that one parent has responsibility for the child's health care expenses, then the program of that parent is primary.
- The benefits of the program which covers a person as an active employee or his/her dependents will be determined before the benefits of a program which covers such person as a laid-off or a retired employee or his/her dependents. If the other benefit program does not have this rule and, as a result, do not agree

on the order of benefits, this rule will not apply.

- If none of the above rules determine the order of benefits, the program that has covered the patient for the longer period is the primary program.

Please note: There is no coordination of benefits if you and/or your spouse are covered by more than one NJ PLUS contract.

NJ PLUS will provide its regular benefits in full when it is the primary plan. As a secondary plan, NJ PLUS will provide reimbursement up to its regular benefit which when added to the benefits under other group plans will not exceed **100 percent** of the eligible charges.

If you enroll in NJ PLUS and your spouse has primary coverage through another plan, your spouse's visits to his/her primary care physician (PCP), under NJ PLUS, are covered in full with a \$5.00 co-payment. Office visits to PCPs are covered under NJ PLUS as if NJ PLUS were the primary plan. All other services are subject to regular COB rules.

If your spouse is referred to a NJ PLUS specialist or goes to an in-network obstetrician/gynecologist, chiropractor, or optometrist or ophthalmologist for an annual vision examination, your spouse need only give the provider the \$5.00 co-payment plus any assistance required in completing claim forms to submit the charge to the spouse's primary coverage. His/her plan will pay its benefit first, and NJ PLUS will cover the balance to the provider according to the in-network rules. If the visit is to an out-of-network provider, normal COB rules apply.

PLAN BENEFITS

IN-NETWORK BENEFITS

You can benefit most from NJ PLUS when you use in-network benefits which means obtaining your care from network providers and having your care managed by your primary care physician (PCP). When you are treated in-network, you are covered for treatment of illness or injury and for well-care and preventive services. The plan will pay, in most cases, the full cost after a small co-payment of \$5.00 per visit. Some services, such as **durable medical equipment**, outpatient mental health care, drugs, and ambulance are paid at 90 percent. When your out of pocket amounts total \$400 per individual/\$1,000 per family, the plan will pay 100 percent of the reasonable and customary allowance for these services.

Your PCP becomes your personal healthcare consultant by managing the level of care you receive and by referring you to the appropriate network specialists and hospitals. If your PCP determines that you require specialty care, (s)he will refer you to a NJ PLUS specialist. If your PCP determines you require hospitalization, then s(he) will refer you to a NJ PLUS hospital and arrange for admission. If the specialty care or hospital service needed cannot be provided by a network specialist or hospital, then the patient will be referred to an appropriate non-network specialist or hospital. In the event this occurs, with the approval of NJ PLUS, the benefits will be provided as in-network. A summary of benefits for in-network services begins on page 27.

Selecting a Primary Care Physician (PCP)

When you enroll in NJ PLUS, you and each covered family member are asked to select a Primary Care Physician (PCP) from the NJ PLUS Provider Network, to coordinate your health care. Each family member may select his or her own PCP. You may choose a PCP from NJ PLUS participating family practitioners, internists, general practitioners and pediatricians. Female patients may visit any participating obstetrician/gynecologist for related treatment without a referral from their PCP. NJ PLUS covers an annual eye examination by a participating ophthalmologist/optometrist. You do not need a referral from your PCP for this examination.

How to Access Information That Will Help You Choose a PCP

The *NJ PLUS Provider Directory* is available to help you find a physician, or to determine that a physician you wish to use is in the NJ PLUS network. You may request a copy of the *NJ PLUS Provider Directory* by calling 1-800-414-SHBP (7427).

The SHBP also offers the Unified Provider Directory (UPD). Updated monthly, the UPD is available over the Internet and contains medical provider information for all of the SHBP's participating health plans. This information is in a uniform, easy to use format and displays timely and comprehensive information concerning health care providers and facilities that deliver their services through NJ PLUS. The site can be reached through the SHBP homepage at: www.state.nj.us/treasury/pensions/shbp.htm

OUT-OF-NETWORK BENEFITS

NJ PLUS allows you the option of using out-of-network providers and receiving reimbursement for the services provided. When you go out-of-network, NJ PLUS covers hospital and other medical services similar to traditional or indemnity plans. You are using out-of-network benefits when you use a non-network provider and when you go directly to a network specialist without a referral from your PCP (visits to network chiropractors and obstetrician/gynecologists need no referral). When you exercise this out-of-network option, you incur an annual deductible and a coinsurance requirement of 30 percent of reasonable and customary allowances, and any amounts exceeding the reasonable and customary allowances. Additionally, NJ PLUS does not include well-care or preventive care in the out-of-network benefits. **If you use a non-network provider, all services, supplies, tests, etc. ordered by that provider including hospitalization, whether or not the hospital is in-network, will be paid at the out-of-network level.**

Deductibles

NJ PLUS has two separate deductibles. There is an annual deductible that each member must meet before an out-of-network charge is paid, and there is a deductible of \$200 for each inpatient out-of-network hospital stay.

The annual individual deductible for out-of-network services is \$100. This means that it is your responsibility to pay the first \$100 in medical bills each year. The actual deductible amount varies with the type of coverage you have:

- Single - \$100;
- Husband and Wife - \$100 per person
- Parent and Child(ren) - \$100 for you, \$100 for one of your children, and up to \$50 for any one of your other children for a maximum family deductible of \$250.
- Family - \$100 for you, \$100 for one other family member, and up to \$50 for any one of your other family members for a maximum family deductible of \$250.

The benefit year in which the deductible is measured runs from January 1 to December 31. However, if treatment for an illness or injury is provided during the last three months of the year the eligible charges that were applied toward the deductible may be counted toward meeting the deductible for the following year.

For example: you are charged \$100 for an October 3, 2000 doctor's office visit. This is your first claim of the year and no other calendar year deductible has been met; therefore, the full \$100 charge is applied to the deductible for 2000. Since this amount was applied in the last three months of 2000, the full \$100 will be applied towards meeting the 2001 deductible.

If you are enrolling in the SHBP for the first time because your employer has decided to join, previously paid charges in the current calendar year can be used to meet the deductible requirements for NJ PLUS.

For example: you work for a city that is joining the SHBP on July 1, your employer's prior insurance plan had a deductible of \$200, and you have already paid \$200 for yourself and \$200 for two children. When you join the program on July 1, you will be considered to have

met the NJ PLUS deductible for yourself and the other family members for that calendar year. You must submit documentation to NJ PLUS showing charges used to meet the deductible.

Coinsurance

Under NJ PLUS, you are required to pay 30 percent of the cost of eligible out-of-network charges up to the point at which the out-of-pocket amounts for the year total \$2,000 per individual/\$5,000 per family. Once the \$2,000 ceiling has been reached, the plan will pay 100 percent of the reasonable and customary allowance. Since the coinsurance applies to each person in your family, the actual amount you are required to pay each year will depend on the number of dependents on your coverage. Expenses for ineligible services and charges in excess of reasonable and customary allowances do not count toward your out-of-pocket maximums. **Additionally, only preauthorized treatments count toward the NJ PLUS maximum out-of-pocket expense level.**

UTILIZATION MANAGEMENT

Both in-network and out-of-network treatment is subject to Utilization Management (UM), a process used to ensure that treatment is **medically necessary and appropriately** provided. When the treatment is proposed by an in-network provider, the provider is responsible for the UM contact. Out-of-network benefits that are actually payable will also depend on whether the patient has or has not contacted the UM organization in regard to proposed medical treatment and whether the UM organization agrees that the treatment is necessary and appropriate.

Benefits are payable for in-network treatment when they are provided by an in-network provider, the UM organization has been notified to review the treatment, and the UM organization has approved the treatment. Benefits would also be paid on this basis to an out-of-network provider in those instances where the patient is referred to an out-of-network provider by their PCP and is authorized by NJ PLUS.

For out-of-network benefits when the patient has failed to contact Utilization Management, treatment will be considered as unauthorized and expenses will not be applied to the annual out-of-pocket maximum. However, if the treatment is otherwise eligible, reimbursement will be made at 70 percent of reasonable and customary allowances if the deductible has been met.

OVERALL BENEFIT MAXIMUM

For in-network services there is no lifetime benefit maximum. For out-of-network services, there is a lifetime medical maximum benefit of \$1,000,000 for diagnosis and treatment of illness and injuries, with an automatic limited restoration feature. At the start of each calendar year, if the person is still a covered person, any previously used part of a maximum will be restored for future charges up to the lessor of (a) \$2,000 or (b) the amount needed to restore the full maximum.

MENTAL HEALTH BENEFIT MAXIMUM

The maximum benefits for non-biologically-based mental or nervous conditions are listed on pages 57 and 58. The plan also contains a unique automatic restoration provision, which can restore benefits issued for non-biologically-based mental illnesses. This special restoration of benefits is in addition to the restoration provision for the overall plan lifetime benefit maximum. This provision is applicable in the calendar year immediately following the initial calendar year in which benefits are paid for mental illness. The patient must be a covered person at the beginning of the year the restoration begins. The maximum that may be restored in a calendar year is \$2,000. The amount restored will be the lesser of \$2,000 or the amount that will bring the total lifetime benefits to \$50,000. A maximum restoration of \$50,000 is available for the lifetime of the patient. Services for mental and nervous disorders, that are non-biologically-based, have a \$50,000 lifetime maximum with a \$2000 automatic restoration provision for all services in or out-of-network.

Re-Enrollment

If your coverage ends under NJ PLUS and begins again at a later date, benefits reimbursed for mental health and other medical benefits where there are lifetime maximums are activated at the same level as when coverage ended and do not begin at the initial level.

SUMMARY OF COVERED SERVICES AND SUPPLIES

SPECIFIC COVERAGE AREAS

This section lists the types of charges NJ PLUS will consider as covered services or supplies up to its allowance subject to and including, but not limited to, medical necessity and appropriateness, utilization review features, the Schedule of Covered Services and Supplies, or benefit limitations and exclusions.

Acupuncture

Acupuncture treatment is covered when the services are for a diagnosis related to pain management and are rendered by a Licensed Acupuncturist or Licensed Medical Doctor (MD, DO).

Examples of acupuncture services that are not eligible under NJ PLUS include weight loss and smoking cessation.

Alcoholism and Substance Abuse

NJ PLUS covers the treatment of Alcoholism and **Substance Abuse** the same way it would any other illness, if such treatment is prescribed by an eligible provider and it is deemed to be medically necessary at the requested level of care. If you need care you must contact NJ PLUS directly. You do not need a referral from your PCP for this care. For scheduled or emergency treatment relating to substance abuse, or alcoholism, you or your provider should call 1-800-991-5579. You must obtain a pre-treatment authorization for all in-network admissions. If you choose to receive your care out-of-network, you should also call NJ PLUS for pre-treatment authorization in order that your coinsurance, for these services, be applied to your out-of-pocket maximum.

Inpatient or outpatient treatment may be furnished as follows:

- Care provided in a state licensed health care facility.
- Care provided in a licensed **detoxification facility**.
- Care provided at a licensed and State approved **residential treatment** facility, under a program which meets minimum standards of care.

Allergy Testing and Treatment

Most commonly used methods of allergy testing are covered. However, some methods are subject to medical necessity and appropriateness review before eligibility can be determined. This includes, but is not limited to, the following tests:

- RAST (Radioallergosorbent Testing)
- MAST (Multiple Radioallergosorbent Testing)
- FAST (Fluorescent Allergosorbent Testing)
- ELISA (Enzyme-Linked Immunosorbent Assay)

Ambulance

Ambulance use for local emergency transport to the nearest eligible facility equipped to treat the emergency condition is covered subject to medical necessity and appropriateness. If emergency air transport is needed, it must be precertified by calling NJ PLUS at 1-800-414-SHBP (7427).

NJ PLUS does not cover chartered air flights, non-emergency air ambulance, invalid coach, transportation services, or other travel or communication expenses of patients, providers, nurses, or family members.

Audiology Services

Audiology services are covered when rendered by a physician or a licensed audiologist, when such services are determined to be medically necessary and appropriate. Pre-approval is required for these services to be considered at the in-network level of benefits. See exclusions on page 47 for hearing aids and hearing examinations.

Automobile-Related Injuries

NJ PLUS will provide secondary coverage to your mandatory New Jersey Personal Injury Protection (PIP) unless NJ PLUS has been elected as primary coverage by or for the employee covered under this contract. This election is made by the named insured under the PIP program and affects that member's family members who are not themselves the named insured under another auto policy. NJ PLUS may be primary for one member, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

NJ PLUS is secondary to automobile insurance coverage. However, if the automobile insurance contains provisions which made the automobile insurance coverage secondary or excess to NJ PLUS, NJ PLUS will be primary.

If NJ PLUS is primary to PIP or other automobile insurance coverage, benefits are paid in accordance with the terms, conditions, and limits set forth in your contract (see page 45) and only for those services normally covered under NJ PLUS.

Please note: If you elect to have NJ PLUS as primary to PIP, prior notification to Horizon BCB-SNJ is not required. Upon receipt of an auto related claim, Horizon BCBSNJ will request the submission of written documentation, such as a copy of your policy declaration page, for verification of your selection.

If NJ PLUS is one of several health insurance plans which provide benefits for automobile related injuries and the covered employee has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

If NJ PLUS is secondary to PIP, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after PIP has provided coverage, subject to medical appropriateness and other provisions, after application of deductibles and coinsurance, or
- The actual benefits that would have been payable had NJ PLUS been primary.

Biofeedback

Biofeedback to treat a medical or biologically-based mental illness diagnosis is covered like any general condition. Mental health diagnoses that are considered non-biologically-based in nature will be subject to the plan maximums under NJ PLUS.

Birthing Centers

As an alternative to the conventional hospital delivery room care for low-risk maternity patients, NJ PLUS pays for care in birthing centers under contract with Horizon BCBSNJ. Services routinely provided by the birthing centers, including prenatal, delivery, and postnatal care, will be covered in full if the delivery takes place at the center. If complications occur during labor and delivery occurs in an approved hospital because of the need for emergency or inpatient care, this care will also be covered in full. Contact NJ PLUS at 1-800-414-SHBP (7427) to identify eligible birthing centers near you.

Blood

Blood, blood products, blood transfusions, and the cost of testing and processing blood are covered. NJ PLUS does not pay for blood which has been donated or replaced on behalf of the patient.

Breast Reconstruction

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, NJ PLUS will provide coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Prosthesis(es).
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Physical complications at all stages of the mastectomy, including lymphedemas.

Chiropractic Services

Chiropractic services that are determined to be medically appropriate for the diagnosis or treatment of an illness or injury, acute condition, acute exacerbation of chronic conditions, and neuromuscular-skeletal conditions for which there will be some measurable improvement are considered for benefit reimbursement. In order to be considered, the treating Chiropractors must be licensed, the services must be appropriate for the diagnosed condition(s), the services must fall within the scope of practice of a chiropractor in the state in which he is licensed and practicing.

Chiropractic services that are determined to provide maintenance or supportive care are not covered. Maintenance care is defined as care given to reduce the incidence or prevalence of illness, impairment and risk factors and to promote optimal function. Maintenance treatments are considered to be not medically needed and are therefore, not eligible for coverage. Frequently, treatment for a chronic condition, such as a bad back, reaches a plateau. That is treatment brings a member to a point when further treatment cannot be reasonably expected to improve the diagnosed condition. Instead it maintains the member's current condition. When such a point is reached, further treatment is deemed to be maintenance care and is no longer

eligible for coverage. Supportive care is defined as treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. In some instances, chiropractic manipulation may be clinically appropriate (such as treatment of a chronic condition that requires supportive care) yet not be eligible for reimbursement.

Chiropractic utilization will be monitored to identify potential case management opportunities through an ongoing analysis of the claim submission and history. When such cases are identified based on a retrospective review of the claims history, a letter will be sent to you and/or your provider requesting medical records. Any claims incurred subsequent to the date of this letter will require the submission of medical records and a formal treatment plan to establish medical appropriateness as defined by the plan. No additional chiropractic claims will be paid until the records are provided and the review is completed. If the services rendered after the date of the request for records are determined to be ineligible, you will be responsible for payment of all services incurred after the date of the letter notifying you that records have been requested.

All reviews of chiropractic treatment records will be performed by a licensed chiropractor. Reviews will focus on the medical appropriateness of the services and/or whether the condition for which the care is being rendered has reached a level of maximum therapeutic improvement where care may be considered maintenance. Should the patient seek chiropractic care for a new diagnosis or an exacerbation of an existing condition, medical records must be submitted for review. These records, in conjunction with the patient's prior chiropractic treatment history, will be reviewed by a licensed chiropractor. Submission of these documents is not a guarantee of payment.

Congenital Defects

Procedures that are necessary to correct a congenital birth defect, which significantly impairs function, including dental procedures, are covered.

Dental Care

NJ PLUS provides benefits for the removal of bony impacted molars, and will pay for the treatment of accidental injuries, and treatment for mouth tumors if medically necessary.

NJ PLUS may provide coverage for the treatment of accidental dental injuries. An accidental dental injury is considered an injury to teeth (must be sound natural teeth) which is caused by an external factor such as damage caused by being hit by a hockey puck or having teeth broken in a fall on the ice.

The treatment and replacement must occur within 12 months of the accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time limit may be extended.

Breaking a tooth while chewing on food is not considered an accidental dental injury. Examples of ineligible dental services include, but are not limited to, breaking a tooth on a popcorn seed, olive pit, or on a bone in a piece of meat.

Stress fractures in teeth are very common and generally undetectable by X-ray. Stress fractures are often the cause of tooth breakage. Treatment for this type of tooth breakage is con-

sidered a dental service, and is not eligible for reimbursement under NJ PLUS.

Medically necessary hospital and anesthesia charges incurred for dental services are covered for severely disabled members and children who can submit convincing documentation for the medical need for the hospitalization/anesthetic services. Charges for the actual dental procedures would not be eligible for benefit under NJ PLUS.

Diabetic Self-Management Education

Benefits, limited to four visits per year, are included for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of the member's condition.

- Benefits for self-management education and education relating to diet shall be limited to medically necessary visits upon:
 - the diagnosis of diabetes;
 - the diagnosis by a physician or nurse provider/clinical nurse specialist of a significant change in your symptoms or conditions which necessitate changes in your self-management; and
 - determination of a physician or nurse provider/clinical nurse specialist that reeducation or refresher education is necessary.
- Diabetes self-management education is covered when provided by:
 - a physician, nurse provider, or clinical nurse specialist;
 - a health care professional such as a registered dietitian that is recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or
 - a registered pharmacist in New Jersey qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Benefits are provided for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse provider/clinical nurse specialist:

- Blood glucose monitors
- Test strips for glucose monitors and visual reading and urine testing strips
- Insulin
- Injection aid cartridges
- Syringes
- Insulin pumps

- Insulin infusion devices
- Alcohol wipes

Dialysis

Dialysis is covered when the services are provided and billed by an eligible hospital, by a free-standing dialysis center, or by an eligible home health agency. The facility must make arrangements for training, equipment rental, and supplies on behalf of the patient. Home dialysis will be considered when there is documented evidence that the services cannot be performed in an outpatient facility.

Durable Medical Equipment and Supplies

Charges for the rental of **durable medical equipment** needed for therapeutic use are covered. NJ PLUS may cover the purchase of such items when it is less costly and more practical than renting such items. NJ PLUS does not cover the rental or purchase of any items which do not fully meet the definition of durable medical equipment. For in- and out-of-network services it is recommended that costly durable medical equipment be approved by NJ PLUS prior to purchase.

NJ PLUS also covers eligible supplies including surgical dressings, blood and blood plasma, artificial limbs, larynx and eyes, casts, splints, trusses, braces, crutches, respirator oxygen and rental of equipment for its use.

Emergency Medical Services

A medical emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, NJ PLUS shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson, regardless of whether the hospital was affiliated with NJ PLUS. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by NJ PLUS.

If you find yourself in an emergency situation, and notification prior to treatment is not reasonably possible, go directly to the nearest emergency facility. All such treatment received during the first 48 hours after the onset of the medical emergency will be eligible for in-network benefits, regardless of whether such treatment is received in or out of the service area or whether such treatment is furnished by a network provider. You must notify your PCP or NJ PLUS of the medical emergency within those 48 hours. Your PCP must then authorize the continuation of

any necessary medical services in order for any such treatment received after those first 48 hours to continue being eligible for in-network benefits. This means if you are admitted to the hospital through the emergency room, you must notify your PCP or NJ PLUS of the emergency and get authorization for treatment and hospital days beyond the first 48 hours. If you do not notify your PCP or NJ PLUS within 48 hours, you will not receive in-network benefits.

— ***Urgent and After Hours Care***

Urgent care is medically necessary care for an unexpected illness or injury that should be treated within 24 hours, but is not life-threatening. It is medical care you can safely postpone until you can call your Primary Care Physician (PCP). Examples of urgent care include fever, earache, cuts, sprains, and minor burns. In instances like these, call your PCP first for instructions. If your PCP determines your situation is a medical emergency, he or she will refer you directly to an emergency facility. If it is not a medical emergency, your PCP will tell you how to treat the problem yourself or make an appointment to see you. Your PCP or a covering physician is available 24 hours a day, every day.

Contact your PCP for after hours care or care that is required at night or on a weekend or holiday. Again, your PCP will provide instructions on how to treat your problem.

If you go directly to an emergency facility for urgent or after hours care and your situation is not a medical emergency, your care will not be covered at the in-network level of benefits.

— ***Away From Home Care***

Under NJ PLUS you are covered for urgent care when traveling or away from home. Urgent care is medically necessary care for an unexpected illness or injury, not a life threatening condition, but one that should be treated before you return home. If you are traveling out of the service area and need urgent care, call NJ PLUS at 1-800-414-SHBP (7427) before receiving care from a local doctor. If you are unable to contact NJ PLUS before receiving care, call within 48 business hours of receiving care.

When you call NJ PLUS before receiving care or within 48 business hours, eligible, medically necessary services will be paid at the in-network level of benefits. Any necessary follow-up care must be performed or referred by your PCP to receive the out-of-network level of benefits. Follow-up care that is not performed or referred by your PCP will also be paid at the out-of-network level of benefits.

For all medical emergencies, present your NJ PLUS identification card to the hospital representative at the time of treatment. The identification card contains all necessary emergency instructions.

Emergency Room

Each time the member uses the hospital emergency room, the member must pay a co-payment as designated in the Schedule of Covered Services and Supplies, if the member is not admitted within 24 hours.

Federal Government Hospitals

NJ PLUS will pay for eligible charges in hospitals operated by the United States government (Veterans Administration and Department of Defense) as if they were member hospitals, regardless of their location for military patients (military retirees and their dependents and dependents of active duty military personnel), for eligible charges for nonmilitary conditions.

NJ PLUS will pay hospitals operated by the United States government for nonmilitary patients (i.e., patients other than military retirees and their dependents and dependents of active duty military personnel) for eligible charges only if:

- services are for treatment on an emergency basis for accidental injury from an external cause; or
- services are provided in a hospital located outside of the United States and Puerto Rico.

Home Health Care

Home Health care services and supplies are covered only if furnished by providers on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis. Pre-approval of a skilled need is required for these services.

The home health care plan must be established in writing by the member's provider within 14 days after home health care starts and it must be reviewed by the member's provider at least once every 60 days.

Eligible home health services provided by a home health care agency include:

- Part-time skilled nursing services provided by or under the supervision of a registered professional nurse (RN).
- Physical therapy.
- Speech therapy (see page 40).
- Related treatment and services eligible for hospital benefits, except drugs and administration of hemodialysis.
- Medical social services or part-time services by a home health care aide during the period when you are receiving eligible skilled nursing care, physical therapy, or speech therapy services.

A prior inpatient hospital stay is not required to qualify for home health care agency benefits but the patient must be homebound and require skilled nursing care under a plan prescribed by an attending physician.

NJ PLUS does not cover:

- Services furnished to family members, other than the patient.
- Services and supplies not included in the home health care plan.
- Nursing home care or care that is primarily custodial in nature.

Home Hemophilia Treatment

Home hemophilia treatment will be considered when there is documented medical evidence that these services cannot be performed in an outpatient facility.

Hospice Care Benefits

Benefits for hospice must be provided according to a physician prescribed course of treatment approved by NJ PLUS with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

The following hospice services are covered:

- Part-time professional nursing services of an R.N. or L.P.N.
- Home health care aide services provided under the supervision of an R.N.
- Medical care rendered by a hospice care program physician.
- Therapy services (including speech, physical and occupational therapies).
- Diagnostic services.
- Medical and surgical supplies (with prior authorization) and durable medical equipment.
- Prescribed drugs.
- Oxygen and its administration.
- Up to 10 days for respite care.
- Inpatient acute care for related conditions.
- Medical social services.
- Psychological support services to the terminally ill patient.
- Family counseling related to the Eligible Person's terminal condition.
- Dietician services.
- Inpatient room, board and general nursing services for related conditions.

No benefit consideration will be given for any of the following hospice care benefits:

- Medical care rendered by the patient's private physician (would be paid separately under the plan).
- Volunteer services.
- Pastoral services.
- Homemaker services.
- Food or home-delivered meals.
- Non-authorized private-duty nursing services.

- Dialysis treatment.
- Services that are not billed by and payable to an eligible hospice provider.
- Bereavement counseling.

Inpatient benefits for hospice patients are provided at the same level as those provided for non-hospice patients. For more information on hospice care, please call NJ PLUS at 1-800-414-SHBP (7427).

Infertility Treatment

The State Health Benefits Program has established Assisted Reproductive Technology (ART) benefits that were effective as of July 1, 2000, for members of the Traditional Plan, NJ PLUS, and Aetna US Healthcare. See Appendix II on page 60 for plan details.

Immunizations

Immunizations are covered under NJ PLUS at the in-network level of benefits unless they are for travel outside the country or work-related. Well-child immunizations for children less than 12 months of age are the only immunizations allowed at the out-of-network level.

Lithotripsy Centers

Lithotripsy services are covered when they are performed in an approved hospital or lithotripsy center. For information regarding the eligibility of certain centers, please call NJ PLUS at 1-800-414-SHBP (7427).

Lyme Disease Intravenous Antibiotic Therapy Coverage

All intravenous antibiotic therapy for the treatment of Lyme Disease must be pre-certified by NJ PLUS. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

To pre-certify intravenous therapy for treatment of Lyme Disease, your provider should call NJ PLUS at 1-800-414-SHBP (7427). The State Health Benefits Program's policy on Lyme Disease treatment is found in Appendix II and begins on page 63.

Mastectomy Benefits

A hospital stay of at least 72 hours following a modified radical mastectomy and a hospital stay of at least 48 hours is covered following a simple mastectomy, unless the patient in consultation with his physician, determines that a shorter length of stay is medically appropriate.

Maternity/Obstetrical Care

Medical care related to childbirth includes the hospital delivery and hospital stay for at least 48 hours after a vaginal delivery or 96 hours after a cesarean section if the attending provider determines that inpatient care is medically necessary and appropriate.

Services and supplies provided by a hospital to a newborn child during the initial covered hospital stay of the mother and child is covered as part of the obstetrical care benefits.

NJ PLUS also covers birthing center charges made by a provider for pre-natal care, delivery, and post-partum care in connection with a member's pregnancy.

Maternity/Obstetrical Care for Child Dependents

In some instances, NJ PLUS will pay bills related to the birth of a grandchild. In order for benefits to be available, **all** of the following must apply:

- the mother must be enrolled as a dependent;
- the mother resides with the member and must be substantially dependent on the member for support and maintenance;
- the mother is under the age of 23 and unmarried.

Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for coverage of the grandchild under the SHBP only if (s)he obtains legal custody of the child. The mother may apply for COBRA coverage for the newborn.

Mental or Nervous Conditions and Substance Abuse

NJ PLUS covers treatment for **mental or nervous conditions** and for substance abuse, including group therapy. If you need care you must contact NJ PLUS directly. You do not need a referral from your PCP for this care. For a scheduled or emergency mental health, substance abuse, or alcoholism hospitalization, you or your provider must call 1-800-991-5579. You must obtain pre-treatment authorization for all in-network admissions. If you choose to receive your care out-of-network, you must also call NJ PLUS for certification in order for your coinsurance for these services to be applied to your out of pocket maximum.

When the **Care Manager** authorizes a member's treatment for mental or nervous conditions, or substance abuse, coverage will be provided at the in-network level of benefits. Payment will be made at a reduced level, or may not be approved if the Care Manager does not manage, assess, coordinate, direct, and authorize a member's treatment for mental or nervous conditions and substance abuse before expenses are incurred. The Care Manager will review and determine if services rendered were medically necessary and appropriate.

A member may receive covered treatment as an inpatient in an eligible hospital or a substance abuse facility. The member may also receive covered treatment at an eligible hospital or outpatient substance abuse center, or from any eligible provider, psychologist or licensed clinical social worker.

Services rendered for the treatment of a biologically-based mental illness are treated like any other illness and are not subject to the mental health maximums. Biologically-based mental illness includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Nutritional Counseling

NJ PLUS allows three visits per year for nutritional counseling that is medically necessary. The nutritional counseling must be prescribed by a NJ PLUS network provider.

Patient Controlled Analgesia (PCA)

Patient Controlled Analgesia (PCA) is covered when it is medically appropriate, prescribed by a medical doctor, and provided under the guidance of one of the following:

- Doctor;
- Anesthesiologist; or
- Approved home care agency.

Physical Therapy

Medically eligible physical therapy is covered based on one session per day. A session of physical therapy is defined as up to one hour of physical therapy (treatment and/or evaluation) or up to three physical therapy modalities provided on any given day.

Pre-Admission Hospital Review

To obtain in-network benefits all non-emergency hospital and other facility admissions must be reviewed by NJ PLUS before they occur. You or the network hospital or your provider must notify NJ PLUS and request a Pre-Admission Review by phone or facsimile. NJ PLUS must receive the notice and request at least 5 business days or as soon as reasonably possible before the admission is scheduled to occur. For a maternity admission, such notice must be given to NJ PLUS at least 60 days before the expected date of delivery, or as soon as reasonably possible, to obtain in-network benefits.

Pre-Admission Testing Charges

Pre-admission diagnostic X-ray and laboratory tests needed for a planned hospital admission or surgery are covered. NJ PLUS only covers these tests if the tests are done on an outpatient or out-of-hospital basis within seven days of the planned admission or surgery.

However, NJ PLUS does not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred solely due to a change in the member's health.

Preventive Care

Preventive care services, except mammograms and certain immunizations, are not covered out-of-network. In-network benefits for certain covered services and supplies relating to preventive care including related diagnostic X-rays and laboratory tests are provided. The covered preventive care benefits are as follows:

- ***Gynecological Care and Examinations (In-Network Only)***

Gynecological care and examinations are eligible, without a referral from the member's PCP. NJ PLUS provides coverage for one routine gynecological examination per year which may include one routine pap smear, when provided by an in-network gynecologist.

- ***Mammography (In-Network and Out-of-Network)***

NJ PLUS, both in- and out-of-network, covers mammograms provided to a female member. Coverage is provided as follows:

- one baseline mammogram at any age,
- one mammogram every year from age 40 and over.

— ***Pap Smears (In-Network Only)***

Charges involving a routine screening pap smear are covered. This benefit is limited to one pap smear, per year, unless additional tests medically necessary and appropriate for diagnostic purposes.

— ***Routine Physicals and Immunizations (In-Network Only)***

Routine physical examination(s) and adult immunizations for you, your spouse and your dependent children over the age of 12 are covered.

— ***Well-Child Care Benefits (In-Network Only)***

Well-child care for your enrolled dependent children is covered.

— ***Well-Child Immunizations (other than those for children less than 12 months of age) and Lead Poisoning Screening and Treatment (In-Network Only)***

Well-Child immunizations and lead poisoning screening and treatment are covered.

— ***Prostate Cancer Screening (In-Network Only)***

One routine office visit per benefit period is covered for adult members, including a digital rectal examination and a prostate-specific antigen test for adult male members over the age of 40. Benefits provided for these services at the out-of-network level are subject to medical appropriateness for the condition being treated.

Private Duty Nursing

Private duty professional nursing is only available under very strict standards. Private duty nursing will only be covered under extraordinary circumstances upon evidence of a clear and convincing objective need.

Private duty nursing must be ordered by a doctor; and provided by one of the following:

- a registered nurse (R.N.), other than yourself, your spouse, or a child, brother, sister, or parent of you or your spouse; or
- a licensed practical nurse (L.P.N.), other than yourself, your spouse, or a child, brother, sister, or parent of you or your spouse.

Private duty nursing will not be covered if the care is:

- the type of care normally provided by or that should be provided by hospital nursing staff;
- rendered by or could be provided by home health care aides;
- custodial care or assistance in the activities of daily living in a home, or facility of any kind.

Scalp Hair Prostheses

A benefit maximum of **\$500** in a **24** month period, per person, is covered for scalp hair prostheses prescribed or authorized by a doctor, only if they are furnished in connection with hair loss resulting from:

- treatment of disease by radiation or chemicals;
- Alopecia Universalis (totalis); or
- Alopecia Areata.

Second Opinion Consulting Services

NJ PLUS provides coverage for a second physician's personal examination of a patient following a recommendation for any eligible surgical procedure. The plan will pay for one consultation by a qualified specialist.

If the second opinion specialist does not confirm the need for surgery, NJ PLUS will provide coverage for one additional consultation if requested by the patient. The plan also will provide coverage for any diagnostic X-rays, laboratory tests, or diagnostic surgical procedures required by the physicians performing the consultations. Coverage for these diagnostic services will be provided even if these services would not otherwise be eligible under NJ PLUS.

Shock Therapy Benefits

NJ PLUS provides benefits for electroshock treatments, insular shock treatments, and other similar treatments. All treatment provided for a non-biologically-based mental illness will be counted towards the annual and lifetime mental health maximums. Benefits are also payable for anesthesia in connection with the shock treatment and for all other eligible services performed on that day for the disorder.

Skilled Nursing Facility Charges

Room, board, including diets, drugs, medicines and dressings and general nursing service in a **skilled nursing facility** are covered.

Speech Therapy Benefit

Speech therapy services provided by a qualified speech therapist are covered as follows:

- Speech therapy services to restore speech after a loss of a demonstrated previous ability to speak or impairment of a demonstrated previous ability to speak. The loss or impairment cannot be caused by a mental, psychoneurotic, or personality disorder.
- Speech therapy to develop or improve speech after surgery to correct a defect that existed at birth and impaired the ability to speak, or would have impaired the ability to speak.

In addition, speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of Otitis Media and one or more myringotomy(ies).

Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed are not covered under NJ PLUS.

Surgical Services

— Multiple procedures

If multiple procedures are performed during the same operative session, the procedure with the highest charge will be considered the primary procedure and the full reasonable and customary (R&C) allowance will be allowed for that primary procedure minus any applicable deductible and coinsurance liability. All additional procedures performed in the same operative session will be paid at 50 percent of the R&C allowance. This is consistent with the way the health insurance industry generally reimburses for multiple procedures.

— Bilateral procedures

Bilateral procedures will be paid at 150 percent of the R&C allowance for one procedure. Services qualify as bilateral when anatomically there are two specific body parts such as ears, eyes, knees, breasts, and kidneys. A lesion on the right arm and a lesion on the left arm would not qualify as bilateral since the skin is one body organ.

Temporomandibular Joint Disorder (TMJ) and Mouth Conditions

Medical and surgical services performed for the treatment of the jaw are covered. Services in relation to the teeth in any manner are excluded. Charges for doctor's services or X-ray examinations for a mouth condition are not eligible.

Charges for dental or orthodontic services for a TMJ diagnosis are not eligible. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of TMJ or malocclusion involving joints or muscles by methods including but not limited to crowning, wiring or repositioning of teeth and dental implants.

Organ Transplant Benefits

Pre-approved services and supplies for the following types of transplants are covered:

- Lung
- Liver
- Heart
- Pancreas
- Certain autologous bone marrow
- Cornea (pre-approval not required out-of-network)
- Kidney (pre-approval not required out-of-network)

Benefits include surgical, storage and transportation services which are directly related to the donation of the organ and billed for by the hospital.

Vision Care Benefits (In-Network Only)

NJ PLUS covers an annual eye examination by a participating ophthalmologist or optometrist. You do not need a referral from your PCP for this annual routine examination. Any visits to an ophthalmologist or optometrist other than for the annual examination will be covered at the in-network level only when you have a referral from your PCP. There are no benefits available for frames, lenses, or contact lenses. There is no out-of-network preventive vision care benefit.

UTILIZATION REVIEW APPEAL PROCEDURE

If you are not satisfied with any utilization review decision, including but not limited to hospitalization admission denials or a reduction of benefits payable, you or your provider may appeal such decision by writing to NJ PLUS. A nurse reviewer will collect any additional medical information required and submit the case to a NJ PLUS appeal physician designated by NJ PLUS. This physician will review the case with the reviewer who made the initial decision. The appeal physician may discuss the case with your provider. You or your provider will be notified of the appeal recommendation.

You (or a provider acting on your behalf and with your consent) may appeal any administrative and utilization management determinations made by NJ PLUS with respect to its coverage. These determinations involve benefit issues - including denials, terminations, or other limitations of covered services and supplies.

First Level Appeal

You initiate the appeal process by calling 1-800-414-SHBP (7427) to receive instructions on how to submit a written appeal. All First Level Appeals must be made within 12 months from the date you were notified of the original determination.

A provider initiates an appeal by writing to the provider services representative or NJ PLUS Utilization Department. All pertinent information will be reviewed by a NJ PLUS Medical Director and a decision will be made on the appeal.

A First Level Appeal must be submitted in writing, dated and signed, with the following information:

- name(s) and address(es) of the member(s) or providers involved;
- the member's NJ PLUS identification number;
- date(s) of service;
- details regarding the actions in question;
- the nature and reason behind the appeal;
- the remedy sought; and
- all documentation to support the appeal.

Second Level Appeal

If either you or your provider is not satisfied with the determination made on your First Level Appeal, you can file a Second Level Appeal before other health care professionals selected by NJ PLUS who were not involved in the initial determination. You or your provider will receive notification of the final determination of the Second Level Appeal, the reasons therefore and instructions for filing an external appeal.

External Appeal

If you are dissatisfied with the results of NJ PLUS internal appeal process, you or your legal

representative can appeal in writing to the State Health Benefits Commission. The right to such an appeal is contingent upon full compliance with both stages of the NJ PLUS internal appeal process. Requests for consideration must be directed to the Appeals Coordinator, P.O. 299, Trenton, NJ 08625-0299 and must contain the reason for the disagreement and a copy of all relevant correspondence and documentation. Appeals are considered at regular monthly meetings of the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps(s) he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, in writing within 45 days, to the Commission that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

CHARGES NOT COVERED BY THE PLAN

- Automobile accident-related injuries or conditions. NJ PLUS does not pay for the treatment of injuries or conditions related to an automobile accident if automobile insurance could have or should have covered the treatment. This exclusion applies to, but is not limited to:
 - existing motor vehicle insurance contracts;
 - motor vehicle contracts that were purchased but have since lapsed;
 - motor vehicle insurance coverage that should have been purchased; and
 - failure to make timely claims under a motor vehicle insurance policy.
- Autopsy.
- Care that is primarily custodial in nature.
- Chair and stair lifts.
- Charges above the reasonable and customary allowance.
- Charges for services or supplies not specifically covered under the plan.
- Charges that should have been paid by Medicare, if Medicare coverage had been in effect.
- Charges incurred prior to legal adoption.
- Charges for the completion of a claim form, photocopies of pertinent medical information or medical records.
- **Cosmetic** procedures - charges connected with curing a condition by cosmetic procedures. This provision does not apply if the condition is due to an accidental injury that occurred while the injured person is enrolled in the plan. Among the services that are not covered are:
 - removal of warts, with the exception of plantar warts;
 - spider vein treatment; and
 - plastic surgery when performed primarily to improve the person's appearance.
- Costs involving surrogate motherhood.
- Court ordered services or treatments.
- Custom-molded shoes.
- **Durable medical equipment** or supplies which are specifically excluded from coverage. To determine coverage for equipment or supplies, call 1-800-414-SHBP (7427).
- Educational or developmental services or supplies. This includes services or

supplies that are rendered with the primary purpose being to provide the person with any of the following:

- training in the activities of daily living (this does not include training directly related to the treatment of an illness or injury that resulted in a loss of a previously demonstrated ability to perform those activities);
- instruction in scholastic skills such as reading and writing;
- preparation for an occupation;
- treatment for learning disabilities; or
- a service or supply that is being provided to promote development beyond any level of function previously demonstrated.

In the case of a hospital stay, the length of the stay and hospital services and supplies are not covered to the extent that they are determined to be allocated to the scholastic education or vocational training of the patient.

- Experimental or investigational services or supplies and charges (see page 17).
- Eye care including (see exceptions under Vision Care Benefits on page 42):
 - out-of-network examinations to determine the need for glasses or lenses of any type, typically known as refraction examinations regardless of the diagnosis;
 - frames, lenses, or contact lenses of any type except initial replacement for loss of the natural lens after cataract surgery;
 - low vision aids; or
 - eye surgery, such as radial keratotomy, or lasik procedures to correct myopia (nearsightedness), hyperopia (far sightedness), or astigmatism (blurring) whether performed for cosmetic or work-related purposes.
- Foot conditions - charges for doctor's services for:
 - a weak, strained, flat, unstable or imbalanced foot, metatarsalgia, or a bunion. However, this exclusion does not apply to an open cutting operation; and
 - one or more corns, calluses, or toenails. This exclusion does not apply to a charge for the removal of part or all of a nail root and services connected with treating metabolic or peripheral vascular disease.
- Government plan charges including a charge for a service or supplies:
 - furnished by or for the United States government;
 - furnished by or for any government, unless payment is required by law; or
 - to the extent that the service or supply, or any benefit for the charge, is provided by any law or government plan under which the member is or

could be covered. This applies to Medicare and "no-fault" medical and dental coverage when required in contracts by a motor vehicle law or similar law.

- Hearing Aids.
- Hearing examinations to determine the need for hearing aids or the need to adjust a hearing aid, no matter what the cause of the hearing loss.
- Herbal or alternative medicine treatments.
- Hot tubs, saunas, or pools of any type.
- Hypnosis.
- Immunizations and preventive vaccines when out-of-network (see exceptions under Preventive Care on page 38).
- Maintenance treatments - frequently, treatment for a chronic condition, such as a bad back, reaches a plateau. That is treatment brings a member to a point when further treatment cannot be reasonably expected to improve the diagnosed condition. Instead it maintains the members' current condition. When such a point is reached, further treatment is deemed to be maintenance treatment and is no longer eligible for coverage.
- Marriage Counseling.
- Modifications to an auto to make it accessible and/or driveable for a disabled person.
- Modifications to a home to make it accessible for a disabled person.
- Mouth conditions - charges for doctor's services or X-ray examinations for a mouth condition. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint disorders (TMJ) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning of teeth. See page 71 in the Glossary for the definition of a **mouth condition**.
- Nursing home care.
- Over-the-counter supplies, supplements, vitamins, medications, or drugs that do not require a prescription order under Federal law, even if the prescription is written by a physician. These include, but are not limited to, aspirin, vitamins, lotions, creams, oils, formulas, liquid diets, and dietary supplements.
- Personal comfort or convenience items including telephone or television service, haircuts, guest trays, or a private room during an inpatient stay.
- Private rooms in a hospital. If you occupy a private room in a hospital or facility setting, you must pay the difference between the private room rate and the average semiprivate room rate.

- Preventive care/routine screening services - Unless otherwise indicated, NJ PLUS out-of-network does not provide coverage for services or supplies that are considered to be performed for any of the following:
 - routine well-care as part of a routine examination; or
 - services and supplies that are provided for a diagnosis that does not indicate an illness present at the time the service are rendered; and
 - services that are considered preventive or screening in nature.

The following services are examples of out-of-network routine services that are not covered:

- pap smear that is part of a routine annual gynecological examination or recommended due to a family history of disease;
 - PSA (Prostate Specific Antigen) as part of a routine examination or recommended due to a family history of disease. Specific guidelines apply to the eligibility of PSA for non-routine reasons (Therefore, you may wish to request a pre-determination of benefits prior to having services rendered.);
 - all immunizations/vaccinations (except for children under 12 months of age);
 - flu shots/pneumonia vaccines;
 - cancer antigen tests that are performed because of a family history. Specific guidelines apply to the eligibility of cancer antigen tests. Therefore, you may wish to request a pre-determination of benefits prior to having services rendered; and
 - well-care annual physicals.
- For members covered by Medicare, services rendered by providers who do not participate with Medicare are not covered.
 - Services involving equipment or facilities used when the purchase, rental, or construction of them has not been approved in compliance with applicable state and federal laws and regulations.
 - Services or supplies that are not medically needed or not appropriately provided and charges in connection with such services or supplies. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and diagnosis of an illness or injury or make it a covered medical expense.
 - Services that are commonly or customarily provided without charge to the patient. Even when the services are billed, the plan will not pay if they are usually not billed when there is no coverage available.
 - Services and supplies prescribed or provided by an ineligible provider.

- Services rendered before the effective date of coverage or after the termination of coverage date. However if the covered patient is hospitalized as an inpatient and coverage terminates during the stay, that inpatient stay (as long as otherwise eligible) will be covered through to discharge.
- Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed.
- Supportive care - supportive care is defined as treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains. In some instances chiropractic care or physical therapy may be clinically appropriate (such as treatment of a chronic condition that requires supportive care) yet it would not be eligible for reimbursement under NJ PLUS.
- Transport (non-emergency) via ambulance or transport by coach of any kind (air, water, or land).
- War — charges for illness or injury due to a current act of war. War means either declared or undeclared, including resistance or armed aggression.
- Work-related injury or disease. This includes the following:
 - injuries arising out of, or in the course of, work for wage or profit, whether or not you are covered by a Workers' Compensation policy; and
 - disease caused by an injury related to Workers' Compensation law, occupational disease laws, or similar laws; or
 - work-related tests, examinations, or immunizations of any kind required by your work.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and the State Health Benefits Program, you may be subject to prosecution for insurance fraud.

Examples of Non-Covered Services

- Example 1: A physician orders inpatient private duty nursing for a surgery patient. Private duty nursing is not routine while confined in a hospital. The charges for private duty nursing will not be paid.
- Example 2: A physician orders a drug that is FDA-approved but is not commonly used to treat the particular condition. If the plan determines that the use is experimental, the plan will not pay for the drug.
- Example 3: A hospital routinely requires an assistant to be present at certain operations. Other hospitals do not have that requirement. The plan will not pay for the assistant unless it can be demonstrated that the service was medically necessary.
- Example 4: Durable medical equipment or supplies which are specifically excluded from coverage. To determine coverage for equipment or supplies, call 1-800-414-SHBP (7427).

THIRD PARTY LIABILITY (SUBROGATION)

If you or your dependents incur medical expenses as a result of the actions of a third party (anyone other than you or NJ PLUS) and NJ PLUS has made payment for those expenses, NJ PLUS has the right to recover those payments.

This means if your medical expenses are reimbursed through a settlement, satisfied judgment, or other means, you are required to return any benefits paid for an illness or accidental injury to NJ PLUS.

Repayment Agreement

If you receive benefits from NJ PLUS, you must agree in writing to repay the SHBP from any reimbursement from a third party.

The repayment will only be equal to the amount paid by us. However, you may deduct any reasonable costs, such as lawyers' fees or court costs incurred in obtaining the third party payment.

This repayment agreement will be binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or whether the third party has admitted liability for the payment.

Acceptance of services will constitute consent to the provisions of this section.

Recovery Right

If you have received benefits from NJ PLUS as a result of the actions of a third party, the plan may:

- assume your right to receive payment for benefits from the third party;
- require you to provide all information and sign and return all documents necessary to exercise NJ PLUS' rights under this provision, before any benefits are provided under your group's policy;
- require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which NJ PLUS may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

NJ PLUS will not provide any benefits to you if you have received payment from a third party or its insurer for past or future charges for an illness or accidental injury resulting from the negligence, intentional act, or no-fault tort liability of a third party.

WHEN YOU HAVE A CLAIM

FILING A CLAIM

In-Network

Generally you will not have to submit any claim forms to NJ PLUS for reimbursement for treatment from your Primary Care Physician (PCP) or any other network provider. You will simply pay the provider the required co-payment amount and the provider will submit directly to NJ PLUS for the appropriate reimbursement.

Out-of-Network

If you receive treatment out-of-network, claims must be submitted to the appropriate NJ PLUS address. Participating out-of-network Horizon BCBSNJ providers will file medical claims directly. If you do not use a participating provider you must submit the claim for reimbursement.

All mental health and substance abuse claims should be mailed to:

NJ PLUS
199 Pomeroy Road
Parsippany, New Jersey 07054
Phone: 1-800-991-5579

All other claims should go to one of the following addresses.

If your PCP is located in New Jersey, send your claims to:

NJ PLUS
Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 820
Newark, New Jersey 07101-0820
Phone: 1-800-414-SHBP (7427)

If your PCP is located in Pennsylvania, send your claims to:

Pennsylvania Blue Shield
P.O. Box 890072
Camp Hill, Pennsylvania 17089-0072
Phone: 1-800-437-0705

If your PCP is located in New York, send your claims to:

Empire Health Choice
P.O. Box 5049
Middletown, New York 10940-5049
Phone: 1-800-228-4708

If for any reason the claim is not eligible, you will be notified of its ineligibility within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the claim appeal procedures on page 14.

Filing Deadline (Proof of Loss)

NJ PLUS must be given written proof of a loss for which a claim is made under the plan. This proof must cover the occurrence, character, and extent of the loss. It must be furnished **within one year and 90 days of the end of the calendar year in which the services were incurred**. For example, if a service were incurred in the year 2000, you would have until March 31, 2002, to file the claim.

A claim will not be considered valid unless proof is furnished within the above time limit. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon appeal if the reason the proof was not provided in a timely basis was reasonable.

Itemized Bills are Necessary

You must obtain itemized bills from the providers of services for all medical expenses. The itemized bills must include the following:

- Name and address of provider
- Provider's tax identification number
- Name of patient
- Date of service
- Diagnosis
- Type of service
- CPT 4 code
- Charge for each service

Foreign Claims

Bills for services that are incurred outside of the United States should include an English translation and the charge for each service performed. The exchange rate at the time of service should also be indicated on the bill that is submitted for coverage.

Filling out the Claim Form

Be sure to fill out the claim form completely. Include the identification number that appears on your NJ PLUS identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim.

SUBMITTING A CLAIM

Medicare Claims Submission

If a member is a New Jersey resident, has Medicare primary coverage, and receives care within New Jersey, claims will be transmitted automatically from the Medicare carrier to NJ PLUS.

If a member resides in another state and has Medicare primary coverage, the member will

have to submit a copy of the Medicare Explanation of Benefits along with a copy of the itemized bill and a completed claim form to NJ PLUS.

Authorization to Pay Provider

The medical expense coverage provided by NJ PLUS is not assignable. However, the member (or a qualified dependent in case of the member's death) can, with the agreement of NJ PLUS, request that payment of any benefit for eligible charges payable to the member, instead be paid directly to the provider of service or supplies. Once payment is made to the provider at the member's request, NJ PLUS will not have to pay the benefit again. This direct payment is done as a courtesy to our member and is not an assignment of benefits. In order for benefits to be payable directly to a non-participating provider, the member must authorize this direction of payment by completing the appropriate section of the claim form.

The providers that participate with any BCBS plan will be paid directly for eligible services.

QUESTIONS ABOUT CLAIMS

If you have questions about a hospital claim, hospital benefits, a medical claim, or medical benefits or if you need a claim form, call 1-800-414-SHBP (7427).

APPENDIX I

SUMMARY SCHEDULE OF SERVICES AND SUPPLIES

New Jersey statutes, administrative code, and agreements between the SHBP and Horizon BCBSNJ govern this plan. The following schedule of benefits is a summary description of plan benefits. It is not complete and does not describe all the limitations or conditions associated with the coverage as described in prior sections. All pertinent parts of this handbook should be consulted regarding a specific benefit. Health decisions should not be made on the basis of the information provided in this schedule.

Horizon BCBSNJ will administer the coverage listed in this Schedule of Covered Services and Supplies, subject to the terms, conditions, limitations and exclusions stated within this booklet.

Services and supplies provided by a Primary Care Physician (PCP), which the member selected to coordinate overall health care, or through a referral by a member's PCP are covered at the in-network level.

Services and supplies provided by an out-of-network provider or a provider not referred to or coordinated by a PCP or Care Manager are covered at the out-of-network level.

All treatment for mental or nervous conditions, substance abuse or alcoholism, for both the in-network and out-of-network levels of coverage, must be preapproved and coordinated by the care manager.

YOUR SHARE OF COSTS

(A \$5 co-payment applies to in-network services unless otherwise indicated)

Coinsurance

In-Network	Unless otherwise indicated, eligible charges are covered in full, after applicable co-payment
Out-of-Network	30 percent of covered charges

Maximum Out of Pocket

In-Network	\$400 per year/individual coinsurance only \$1000 per year/family coinsurance only
Out-of-Network	\$2,000 per year/individual \$5,000 per year/family

Note: The Maximum Out of Pocket cannot be met with:

- Non-Covered Charges
- Deductibles
- Co-payments

— Amounts above the reasonable and customary allowance.

Deductible/ Out-of-Network (see Deductibles on page 24)

\$100/Member.

\$250/family and parent/child (\$100 for you, \$100 for spouse or one child, and \$50 for a third person)

Hospital Admission Deductible

Out-of-Network **\$200** per admission

MAXIMUM PLAN BENEFITS

In-Network **Unlimited.** Applies to all covered services and supplies.

Out-of-Network **\$1,000,000.** Applies to all covered services and supplies.

MENTAL HEALTH MAXIMUMS

For Non-Biologically-Based Mental Illnesses

**In-Network and
Out-of-Network,
(Combined Maximum)** **\$15,000** per calendar year/ \$50,000 lifetime

ELIGIBLE SERVICES AND SUPPLIES

Acupuncture for Pain Management Only

In-Network **100 percent** coverage

Out-of-Network **70 percent** coverage

Inpatient Alcohol or Substance Abuse

In-Network **100 percent** coverage

Out-of-Network **70 percent** coverage, subject to **\$200** hospital deductible

Outpatient Alcohol or Substance Abuse

In-Network **100 percent** coverage (no co-payment)

Out-of-Network **70 percent** coverage

Allergy Testing and Treatment

In-Network **100 percent** coverage

Out-of-Network **70 percent** coverage

Ambulance Services

In-Network	90 percent coverage
Out-of-Network	70 percent coverage

Ambulatory Surgery

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Anesthesia

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Biofeedback for General Conditions

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Biofeedback for Non-Biologically-Based Mental Illnesses

In-Network	90 percent coverage up to Mental Health Maximums
Out-of-Network	70 percent coverage up to Mental Health Maximums

Chiropractic Services (No Referral Required)

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Diagnostic Laboratory

In-Network	100 percent coverage (no co-payment)
Out-of-Network	70 percent coverage

Diagnostic X-ray

In-Network	100 percent coverage (\$5 co-payment at a facility other than a hospital)
Out-of-Network	70 percent coverage

Dialysis Center Charges

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Durable Medical Equipment

In-Network	90 percent coverage
Out-of-Network	70 percent coverage

Emergency Room

In-Network	100 percent coverage, after a \$25.00 co-payment* (if reported within 48 hours) 70 percent coverage, if not reported within 48 hours)
Out-of-Network	100 percent coverage, after a \$25.00 co-payment* (if reported within 48 hours) 70 percent coverage, if not reported within 48 hours)

*For both in- and out-of-network services the \$25 co-payment amount is waived if admitted.

Hospital Charges

In-Network	100 percent coverage, subject to pre-approval
Out-of-Network	70 percent coverage, subject to hospital deductible

Home Health Agency Care

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Hospice Care

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Inpatient Physician Services

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Maternity/Obstetrical Care

In-Network	100 percent coverage, after a \$5.00 co-payment for initial visit
Out-of-Network	70 percent coverage

Non-Biologically-Based Mental or Nervous Conditions

Inpatient

In-Network	100 percent coverage for up to 25 days per benefit period. Additional services will be covered at 90 percent . Subject to the annual/lifetime maximum.
Out-of-Network	50 days per calendar year at 50 percent subject to a \$200 deductible per confinement and the annual/lifetime maximums.

Outpatient

In-Network	90 percent coverage. Subject to the annual/lifetime maximum.
Out-of-Network	70 percent coverage. Subject to the annual/lifetime maximum.

Inpatient Medical Visits

In-Network	100 percent coverage. Subject to the annual/lifetime maximum.
Out-of-Network	70 percent coverage. Subject to the annual/lifetime maximum.

Nutritional Counseling

In-Network	100 percent coverage (3 visits per year)
Out-of-Network	No coverage

Physical Therapy

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Preadmission Testing

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Preventive Care***— Gynecological Care and Examinations (Routine)***

In-Network	100 percent coverage, no referral is required
Out-of-Network	No coverage for routine care. Care for treatment of a diagnosed condition is covered at 70 percent coverage

— Mammography

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

— PAP Smears

In-Network	100 percent coverage
Out-of-Network	No coverage

— Routine Physicals and Immunizations

In-Network	100 percent coverage
Out-of-Network	No coverage

— ***Well-Child Care***

In-Network	100 percent coverage
Out-of-Network	No coverage

— ***Well-Child Immunizations***

In-Network	100 percent coverage
Out-of-Network	70 percent coverage, if under 12 months of age

— ***Prostate Cancer Screening***

In-Network	100 percent coverage
Out-of-Network	No coverage

Private Duty Nursing

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Second Opinion Charges (Voluntary)

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Skilled Nursing Facility Charges

In-Network	100 percent coverage for up to 120 days per calendar year.
Out-of-Network	70 percent coverage for up to 60 days per calendar year.

Specialist Services

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Speech Therapy

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Surgical Services

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

Transplant Benefits

In-Network	100 percent coverage
Out-of-Network	70 percent coverage

APPENDIX II

STATE HEALTH BENEFITS PROGRAM MEDICAL TREATMENT POLICIES

Infertility Treatment

The following State Health Benefits Program (SHBP) Assisted Reproductive Technology (ART) benefits were effective as of July 1, 2000, for members of the Traditional Plan, NJ PLUS, and Aetna US Healthcare.

[In Vitro Fertilization (IVF), Embryo Transfer (ET), Zygote Intrafallopian Transfer (ZIFT), Gamete Intrafallopian Transfer (GIFT)]

All services must be provided at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology.

Eligible services

- Consultations with infertility specialists and/or at comprehensive infertility centers are covered. Under the Traditional Plan and NJ PLUS out-of-network, screening tests such as HIV, routine PAP, hepatitis panels, etc., which may be required prior to infertility treatments will not be covered expenses. Under HMO and NJ PLUS in-network, those expenses will be covered.
- Ovulation Induction and Monitoring are covered.
- Laparoscopy, laparotomy, and hysteroscopy for diagnosis or treatment of infertility are covered.
- Attempts to reverse prior sterilizations are covered.
- Infertility treatment is covered if the member had a prior sterilization procedure.
- Up to six attempts at artificial insemination are covered when in concert with ovarian hyperstimulation or when using donor sperm. Artificial insemination is less invasive than other infertility procedures and significantly less expensive and should be attempted when it is likely to succeed.
- The SHBP limits the reimbursement of ART procedures (i.e., IVF¹, ZIFT², GIFT³) and related services to three attempts per successful pregnancy. *An attempt is recorded for IVF or ZIFT when egg harvesting or retrieval and either culture and fertilization of oocyte(s) or intracytoplasmic sperm injection (ICSI) is performed;*

¹IVF is In Vitro Fertilization which is a four step procedure. 1) Eggs produced by administering fertility drugs (gonadotropins) are 2) retrieved from the woman's body and 3) fertilized by sperm in a laboratory dish. The resulting embryos are 4) transferred by catheter to the uterus.

²ZIFT is Zygote Intrafallopian Transfer in which eggs are fertilized by sperm in a laboratory dish and resulting embryos are transferred to the woman's fallopian tubes from which they travel naturally to the uterus.

³GIFT is Gamete Intrafallopian Transfer wherein, following hormonal stimulation of egg production, a mixture of sperm and eggs is transferred, using a minor surgical procedure, to the fallopian tubes, where fertilization may occur.

or, with GIFT, when the gametes are actually transferred to the recipient's fallopian tube. A successful pregnancy is defined as producing a live newborn.

Embryo transfers using frozen embryos do not count as a separate IVF or ZIFT attempt. If the first three attempts are not successful, there is no further IVF, ET, ZIFT or GIFT benefit. This is a lifetime benefit maximum regardless of what plan or how many plans provided a service under the SHBP self-funded plans.

Examples of some of the related services that would be covered within the three attempts include initial consultation, office visits, cost of the drug(s), laboratory and/or radiologic procedures, testicular sperm aspiration (TESA) and percutaneous epididymal sperm aspiration (PESA) and the process of cryopreservation of embryos⁴ although not the storage costs. These procedures would all be subject to the member's deductible and coinsurance or co-payment requirements and any lifetime benefit maximum.

- In addition, any necessary ovum or sperm donor costs would be covered, including but not limited to office visits, costs of drugs, laboratory and/or radiologic procedures, retrieval, cryopreservation, etc. but not including costs for transportation, lodging, or any compensation.
- An attempt is recorded based on the criteria as defined regardless of whether fertilization or transfer is successful. This is also true whether or not the pregnancy goes to term, results in a live birth, or if it results in an ectopic pregnancy.
- The number of embryos to be transferred must follow standards set by the American Society of Reproductive Medicine.
- Fetal reductions are covered.
- Blastocyst transfer is covered.
- Assisted hatching techniques are covered, including, but not limited to partial zona dissection, laser zona dissection, zona pellucida, or subzonal drilling.
- Microscopic assessment of oocyte(s), thawing and preparation of cryopreserved embryos, sperm identification from aspiration and preparation for transfer of embryos are covered services.
- The plan may negotiate global fees for Assisted Reproductive Technology services and procedures with providers. Global fees would include office visits, would remain at the prevailing reimbursement rate (customary charge level), and would be based on an attempt basis. Where global fees cannot be negotiated, reasonable and customary allowances will be paid.
- The process of cryopreservation and sperm banking for a male undergoing cancer treatment who may become infertile as a result are covered. Expenses for storage are not covered.

Ineligible services

- Services or procedures that are not eligible for separate or additional reimburse-

⁴Cryopreservation is freezing of embryos after a previous ART cycle for later thawing and transferal to the uterus without the need for repeat stimulation and retrieval during subsequent cycles.

ment since they are considered part of another more global service or procedure include, but are not limited to:

- Medical management fees, cycle management fees, administrative fees, and/or professional management fees billed in addition to office visits.
 - Donor compensation fees
 - Documentation of fertilization
 - Mock transfers
 - Uterine sounding
- The following services are considered investigational and therefore ineligible for benefit:⁵
- Acrosome reaction assay - a diagnostic tool that may be used in the evaluation of male infertility or sub-fertility. The acrosome (part of the sperm) is observed under a microscope for "reaction" after being subjected to a stimulus. Based on the reaction, it is proposed that poorly fertilizing sperms can be differentiated from those with good fertilizing capacity.
 - Subzonal insemination
 - Intratubal insemination
- The following are ineligible for benefit:
- Ovulation kits or sperm testing kits and supplies
 - Donor search fees
 - Cycle management fees or medical management fees
 - Pre-implantation Genetic Diagnosis
 - Storage of frozen embryos or sperm
 - Costs involving surrogate motherhood are not covered.
 - Under the Traditional Plan and out-of-network in NJ PLUS, screening tests are not covered, including the PAP, HIV, hepatitis panels, etc. which are routinely required prior to IVF. These tests are covered under the HMO plans and in-network NJ PLUS.

⁵This list is not all inclusive and does not include all investigational services and procedures. Denials are not limited to those on this list.

Lyme Disease Intravenous Antibiotic Therapy

All intravenous antibiotic therapy for the treatment of Lyme Disease must be pre-certified by NJ PLUS. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

To pre-certify intravenous therapy for treatment of Lyme Disease, please call NJ PLUS at 1-800-414-SHBP (7427).

Diagnosis

All testing should be initiated by antibody capture immunoassay, enzyme-linked immunosorbent assay (ELISA), or immunofluorescence assay (IFA) as "screening" tests. Because these tests are generally sensitive, specimens negative by ELISA or IFA need not be further tested since the diagnosis of Lyme disease can virtually be excluded. However, specimens that are positive, minimally reactive, or equivocal by ELISA or IFA should be confirmed by Western blots because of their relatively low specificity.⁶ If early Lyme Disease is suspected clinically despite a negative antibody titer, serological investigations (starting with ELISA or IFA) should be repeated approximately 2 to 4 weeks later since 60 percent of infected individuals may test negative at the early stage. Antibiotic therapy may prevent an increase in specific antibodies and seroconversion may even occur after antibiotic therapy.

IgM Western blot is considered positive if two of the following three bands are present: 24 kDa (OspC), 39 kDa (BmpA), and 41 kDa (Fla). IgG Western blot is considered positive if five of the following 10 bands are present: 18 kDa, 21 kDa (OspC), 28 kDa, 30 kDa, 39 kDa, 41 kDa (Fla), 45 kDa, 58 kDa (not GroEl), 66 kDa, and 93 kDa.

Serological findings are dependent on disease duration and clinical manifestation.

Early Localized Lyme Disease (Erythema migrans rash)

- With *early localized Lyme Disease*, less than half of patients have detectable specific antibodies, predominantly IgM. Serologic testing is unnecessary.

Covered Treatment: Early localized Lyme Disease should be treated with oral antibiotic therapy, preferably a 21-day course of doxycycline or amoxicillin, not intravenous therapy. [Patients intolerant to those oral medications may be treated with cefuroxime axetil (oral), clarithromycin (oral), or azithromycin (oral).]⁷ Intravenous therapy is not appropriate unless oral medications are not tolerated. If intravenous antibiotic therapy must be used, 14 days of antibiotic therapy is equivalent to 21 days of oral doxycycline.⁸

Early Disseminated Lyme Disease (Erythema migrans rash with multiple lesions,

⁶In the early stage of the disease (localized or even disseminated), there may be isolated IgM reactivity to ELISA or IFA, or in a minority of patients, there may only be an IgG response. Therefore, both IgM and IgG Western blots are recommended in the early stage.

⁷Note: cefuroxime axetil, clarithromycin, and azithromycin have been studied only in early, localized Lyme Disease, and azithromycin has been shown to be inferior to amoxicillin.

⁸"Ceftriaxone compared with doxycycline for the treatment of acute disseminated Lyme Disease." New England Journal of Medicine 1997. 337:289-94.

migratory joint pains and brief arthritis attacks, meningitis, cranial neuritis (usually facial palsy), carditis (usually AV nodal block))

- With early disseminated Lyme Disease, the proportion of detectable specific antibodies rises to 70-90 percent with a switch from IgM to IgG. In order to be considered medically appropriate, the following criteria must be met where applicable:
 - 1) Medical certification of early disseminated disease (disseminated infection with cardiac and neurological problems),
 - 2) Symptomatic pregnant women with failed course of oral antibiotics.

Covered Treatment:

- Early disseminated disease is treated with oral antibiotics (doxycycline 100 mg. twice a day or amoxicillin 500 mg. three times a day for 21 days).
- Facial palsy with meningitis: doxycycline 200 mg. twice a day or ceftriaxone 2 grams daily for 21 days or, if that is not tolerated, may treat with intravenous antibiotic therapy.
- Intravenous therapy is appropriate for Lyme Carditis or AV block with PR interval greater than 0.3 seconds, for children under the age of nine, or if patient is unable to tolerate oral antibiotics (nausea, vomiting, or malabsorption syndrome).
- Oral antibiotic therapy may be medically appropriate instead of intravenous therapy for palpitations in the absence of EKG changes; "funny feeling on one side of the face" in the absence of facial droop; facial palsy with normal cerebrospinal fluid results.

All intravenous therapy for treatment of Lyme Disease must be pre-certified by NJ PLUS. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

Pulse therapy, pulse treatment with Imipenem, therapy with Vancomycin, and diagnostic tests involving urine antigen and urine and serum polymerase chain reaction (PCR) are to be considered investigational.

Late/Chronic Disease Lyme Arthritis and Late/Chronic Disease

Neuroborreliosis, (Persistent infection with prolonged arthritis attacks, chronic encephalomyelitis, chronic axonal polyradiculopathy, acrodermatitis chronica atrophicans)

In order to be considered medically appropriate, the following criteria must be met where applicable:

- Diagnosis based on objective findings including, but not limited to, serologic tests, spinal fluid analysis, neuropsychologic studies, and/or MRI.
- Neuroborreliosis, there is no role for IgM ELISA or Western Blot in late stage disease because the IgM tests have been shown to have a high number of false

positives (low specificity) in patients whose symptoms have been present for more than one month. IgG Western Blot is usually sensitive and specific in this stage. IgG titers are usually high and may remain so for several years, even when treatment is successful. Elevated serum IgG alone indicates previous exposure to *B. burgdorferi* but not necessarily recent or active infection. In no case should serologic reactivity be considered synonymous with active infection.

- Spinal fluid analysis is mandatory in testing for neuroborreliosis unless a patient has a reactive serum test with a confirmatory IgG Western blot and signs of neurologic disease. If a patient has a clinical picture consistent with neuroborreliosis, spinal fluid analysis may be appropriate even in the absence of a positive serologic test. Intravenous antibiotic therapy will not be covered for possible neuroborreliosis in the absence of a reactive serologic test without performing further studies to confirm the diagnosis, i.e., CSF analysis and neuropsychological testing or SPECT scanning.⁹
- Expressing cerebrospinal fluid (CSF) and serum ELISA results as a ratio may help correct for passive diffusion of anti-Borrelia antibodies across the blood brain barrier and can also be used to support (but not confirm) a clinical diagnosis of neuroborreliosis. If the patient has cognitive dysfunction, neuropsychologic studies should be done. If there is peripheral nerve damage, EMG and nerve conduction velocity (NCV) studies are indicated: if there are sensory changes only, somatosensory evoked potentials (SSEP) are in order.

Covered Treatment: may be treated with up to 30 days of intravenous antibiotic therapy.

A second or extended course of intravenous therapy must be pre-certified by NJ PLUS at its sole discretion prior to extending the course of therapy. There must be sufficient objective evidence, including objective clinical and laboratory findings, of new or extended manifestations of the disease. The plan administrator may require a consultation with an appropriate specialist.

Note: Requests for more than 30 days require clinical/laboratory documentation of the need.

A second course of intravenous therapy is warranted for any one of the following indications:

- clinical evidence of recurrent or new synovitis if other causes have been ruled out;

⁹Single photon emission computed tomography (SPECT) scanning in and of itself is not suitable to establish the diagnosis of Lyme Disease. It is, however, useful to evaluate regional cerebral blood flow and is to be covered by the plan administrator for patients suspected of Late/Chronic Neuroborreliosis. SPECT scanning has been reported to show at six months that perfusion abnormalities improve in patients with Lyme encephalopathy after a one-month course of intravenous ceftriaxone. Therefore, it may be helpful to demonstrate whether a patient with suspected Lyme Disease actually has encephalopathy and may be helpful to follow response to therapy. SPECT scanning is not required in all patients and should only be used as an adjunct to other diagnostic tests when there is uncertainty as to the patient's diagnosis or response to therapy.

- clinical evidence of recurrent or new objective neurologic physical findings in the absence of other explanations;
- laboratory evidence of persistent (non-improving) CSF pleocytosis if other causes have been ruled out (if the spinal fluid showed a marked improvement but not complete resolution of the pleocytosis soon after completing therapy, another course of therapy may not be warranted);
- laboratory evidence of persistently positive CSF and/or synovial fluid culture, i.e., positive after initial intravenous treatment;
- laboratory evidence of positive Polymerase Chain Reaction¹⁰ (PCR) in CSF¹¹ and/or synovial fluid - PCR urine or blood tests are not to be considered.

Extended intravenous therapy beyond 30 days as a second course may be approved only if there is:

- recurrent Lyme arthritis with active synovitis after a 30-day course of appropriate antibiotics (ceftriaxone, cefotaxime, penicillin G); or
- recurrent neuroborreliosis, documented by CSF pleocytosis, CSF culture, or PCR of CSF¹², or neuropsychological studies.

Examples of cases where an extension or repeat course of intravenous therapy may be medically appropriate include: a patient who had left knee arthritis and received treatment only to develop neurologic disease or arthritis of another joint after termination of treatment; a patient who had treatment of established Lyme Disease in the past and now develops new findings with increasing reactivity with *Borrelia Burgdorferi* as indicated by expansion of the immunologic reactivity with new bands on Western blot.

¹⁰PCR testing of CSF and synovial fluid are to be covered by the plan administrator for patients suspected of Late/Chronic Lyme Disease. Coverage for PCR testing for other uses or fluids will be determined by the plan administrator.

¹¹A persistently positive PCR in spinal fluid should be interpreted with caution. It's not really known what it means. In conjunction with other clinical/laboratory data, it may help support the need for a second course of antibiotics. In and of itself, it would not mandate therapy.

¹²It would be reasonable to extend or repeat treatment if a patient had a persistently positive CSF PCR and ongoing symptoms.

APPENDIX III

GLOSSARY

Accidental Injury — physical harm or damage done to a person as a result of a chance or unexpected occurrence.

Active Group Member — an employee who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the SHBP for him or herself and, if applicable, any eligible dependents. Also includes eligible employees or dependents who continue SHBP coverage as a subscriber in the SHBP's COBRA program.

Activities of Daily Living — day-to-day activities, such as dressing, feeding, toileting, transferring, ambulating, meal preparation, and laundry functions.

Allowable Expense — the allowance for charges for services rendered or supplies furnished by a health care provider that would qualify as a covered expense.

Ambulatory Surgical Center — an accredited ambulatory care facility licensed as such by the state in which it operates to provide same-day surgical services.

Appeal — a request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the State Health Benefits Commission may only be filed by a member or the member's legal representative.

Benefit Period — the twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on your coverage date. The last Benefit Period ends when you are no longer covered.

Biologically-Based Mental Illness — approved diagnosed conditions include to date, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Blue Card Program — a national Blue Cross Blue Shield (BCBS) electronic claims billing program through which participating hospitals and doctors can transmit bills for BCBS plan members to any BCBS-administered health insurance program.

Calendar Year — a year starting January 1 and ending on December 31.

Care Manager — a person or entity designated by Horizon BCBSNJ to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered

employees and their dependents to remain on group insurance plans, for limited time periods, at their own expense under certain conditions.

Coinsurance — the portion of the eligible charge which is the member's financial responsibility for out-of-network services.

Coordination of Benefits — the practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement does not exceed 100 percent of the actual expense, and (3) the plan does not pay more than it would if no other insurance existed.

Co-payments — the fee charged to a member or patient to be paid directly to the PCP or network specialist at the time treatment is rendered for certain covered services.

Cosmetic — services rendered to beautify the body serving to correct physical imperfections rather than functional need.

Coverage — the plan design of payment for medical expenses under the program.

Custodial Care — services that do not require the skill level of a nurse for performance. These services include but are not limited to assisting with activities of daily living, meal preparation, ambulation, cleaning and laundry functions.

Deductible — the portion of the first eligible charges submitted for payment in each calendar year that the out-of-network portion of NJ PLUS requires the member or covered dependent to pay.

Dependent Coverage — coverage of an eligible family member of an enrolled member.

Detoxification Facility — a health care facility licensed by the state it is in as a detoxification facility for the treatment of alcoholism and/or substance abuse.

Durable Medical Equipment — equipment, which is designed and able to withstand repeated use and is customarily used to serve a member with a medical condition.

Eligible Services and Supplies — these are the charges that may be used as the basis for a claim. They are the charges for certain services and supplies to the extent the charges meet the terms as outlined below:

- Medically needed and appropriate treatment for the medical condition.
- Listed in covered services and supplies.
- Ordered by a doctor (as defined by the plan) for treatment of illness or injury.
- Not specifically excluded (listed in the "Charges Not Covered by the Plan" section).
- Provided while you or your eligible family members were covered by the plan.

Emergency — a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or a guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of bodily organ or part.

Claims will be paid for emergency services furnished in a hospital emergency department if the presenting symptoms reasonably suggested an emergency condition as would be interpreted by a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency condition will be covered.

Facility Charges — charges from an eligible medical institution such as a hospital, residential treatment center, detoxification center, ambulatory or freestanding surgical center, dialysis center, or a skilled nursing center.

Family or Medical Leave of Absence — a period of time of predetermined length, approved by the employer, during which the employee does not work, but after which the employee is expected to return to active service. Any employee who has been granted an approved leave of absence in accordance with the Family and Medical Leave Act shall be considered to be active for purposes of eligibility for covered services and supplies.

Full Medicare Coverage — enrollment in both Part A (Hospital Insurance) and Part B (Medical Insurance) of the federal Medicare Program. ***State law requires that anyone who is enrolled in the Retired Group and is eligible for Medicare must enroll in both Parts A and B of the Medicare Program in order to be covered in the State Health Benefits Program.***

Government Hospital — a hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county or city hospital.

Home Health Care Agency — a provider which mainly provides skilled nursing care and therapeutic services for an ill or injured person in the home under a home health care program designed to eliminate hospital stays. To be eligible for reimbursement it must be licensed by the state in which it operates, or be certified to participate in Medicare as a home care agency.

Hospice — a provider that renders a health care program which provides an integrated set of services designed to provide comfort, pain relief and supportive care for terminally ill or terminally injured people under a hospice care program.

Hospital — an approved institution that meets the tests of (1), (2), (3), (4), or (5) below:

- (1) It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.
- (2) It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities.
- (3) It is licensed as an ambulatory or freestanding surgical center. The center must mainly provide outpatient surgical care and treatment.

(4) It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:

- A licensed hospital; or
- A licensed detoxification facility; or
- A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals.

(5) It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets all of the following tests:

- It is equipped and operated mainly to provide an alternative method of childbirth.
- It is under the direction of a doctor.
- It allows only doctors to perform surgery.
- It requires an examination by an obstetrician at least once before delivery.
- It offers prenatal and postpartum care.
- It has at least two birthing rooms.
- It has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator.
- It has the services of registered graduate nurses.
- It does not allow patients to stay more than 24 hours.
- It has written agreements with one or more hospitals in the area that meet the tests in (1) or (2) above and will immediately accept patients who develop complications or require post-delivery confinement.
- It provides for periodic review by an outside agency.
- It maintains proper medical records for each patient.

"Hospital" does not include a nursing home. Neither does it include an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care, or for the aged or drug addicts.
- Is used mainly as a center for the treatment and education of children with mental disorders or learning disabilities.
- Provides homelike or **custodial care**.

Illness — any disorder of the body or mind of a covered person, but not an injury.

Injury — damage to the body of a covered person.

Local Employee — for purposes of SHBP coverage, a local employee is a full-time employee

receiving a salary and working for an employer that participates in the SHBP. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 20 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language, is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer — public employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Medically Necessary and Appropriate — a service or supply that NJ PLUS determines meets each of these requirements:

- It is ordered by a doctor for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.
- It is furnished by an eligible provider with appropriate training, experience, staff, and facilities to furnish this particular service or supply.

Medicare — the federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medical coverage consists of two parts: Part A is Hospital Insurance Benefits and Part B is Medical Insurance Benefits. A Retired Group member and/or spouse who are eligible for Medicare coverage by reason of age or disability must be enrolled in Parts A and B to enroll or remain in SHBP Retired Group coverage.

Member — an employee, retiree, or dependent who is enrolled under NJ PLUS.

Mental or Nervous Condition — a condition which manifests symptoms which are primarily mental or nervous, whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and regardless of cause, basis or inducement, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental or nervous conditions include, but are not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. Mental or nervous condition does not include substance abuse or alcoholism.

Mouth Condition — a condition involving one or more teeth, the tissue or structure around them, or the alveolar process of the gums.

Off-label Use — a drug not approved by the FDA for treatment of the condition in question or prescribed at a different dosage than the approved dosage.

Out-of-Network Benefits — benefits provided by NJ PLUS when members do not use network providers for their medical treatment or do not follow the managed care guidelines, i.e., go directly to a network specialist without obtaining a referral from the **Primary Care Physician**.

Point of Service — a plan that provides managed care to its members through its own network of providers. The plan also provides reimbursement to members for services rendered by non-network providers at a lower reimbursement rate and subject to a calendar year deductible. In a point of service plan, you must choose a PCP to manage your healthcare.

Participating Provider — a doctor or hospital which has a written agreement with their local Blue Cross Blue Shield plan to provide care to both that plan's members and other Blue Cross Blue Shield plan members.

Primary Care Physician — a participating provider who provides basic healthcare services to, and arranges specialized services for, those members who select that provider as their Primary Care Physician (PCP).

Provider — under the SHBP, the term is used to define an eligible provider and includes medical doctors, dentists, podiatrists, acupuncturists, psychologists, psychiatrists, nurse midwives, licensed clinical social workers, chiropractors, certified nurse practitioners, clinical nurse specialists, physical therapists, occupational therapists, optometrists, and audiometrists who are properly licensed and are working within the scope of their practice.

Reasonable and Customary — the plan makes payments based on the reasonable and customary (R&C) allowance for supplies and services in a specific geographic area. The R&C allowance is the general level of charges made by others in the area for like services or supplies as determined by the Prevailing Healthcare Charges System (PHCS). This schedule is updated on a semi-annual basis. R&C allowances are based on actual charges by physicians in a specific geographical area for specific services.

Residential Treatment Facility — a health care facility licensed, certified, or approved by the State of New Jersey for treatment of alcoholism or substance abuse or meeting the same standards, if out-of-state.

Retired Group Member — an eligible retiree of a state-administered or local public pension fund who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving spouse of a deceased Retired Group member who has met the requirements for and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him/herself and, if applicable, any eligible dependents. Also includes a surviving dependent child of a deceased Retired Group member who had parent-child(ren) coverage, providing (s) he has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP.

SHBP Member — an individual who is either a SHBP Active Group, Retired Group, or COBRA participant, and their dependents.

Skilled Nursing Facility — a facility which is approved by either the Joint Commission on Accreditation of Health Care Organizations or the Secretary of Health and Human Services and provides skilled nursing care and services to eligible persons. The skilled nursing facility provides a specific type of treatment that falls midway between a hospital that provides care for acute illness and a nursing home that primarily provides assistance with daily living.

State Biweekly Employee — for purposes of SHBP coverage, state biweekly employee shall mean a full-time employee of the State, or an appointed or elected officer, paid by the State's centralized payroll system whose benefits are based on a biweekly cycle. Full-time normally requires 35 hours per week.

State Monthly Employee — for purposes of SHBP coverage, state monthly employee shall mean a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

State Monthly Employer — employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- State legislature and legislative offices
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

Substance Abuse — the abuse or addiction to drugs or controlled substances, not including alcohol.

Surgical Center — also termed as surgicenter. An ambulatory-care facility licensed by a state to provide same-day surgical services.

Surgical Procedure — this includes cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, application of plaster casts, electrocauterization, tapping (paracentesis), administration of pneumothorax, endoscopy, or injection of sclerosing solution.

Waiting Period — the period of time between enrollment in the State Health Benefits Program and the date when you become eligible for benefits.